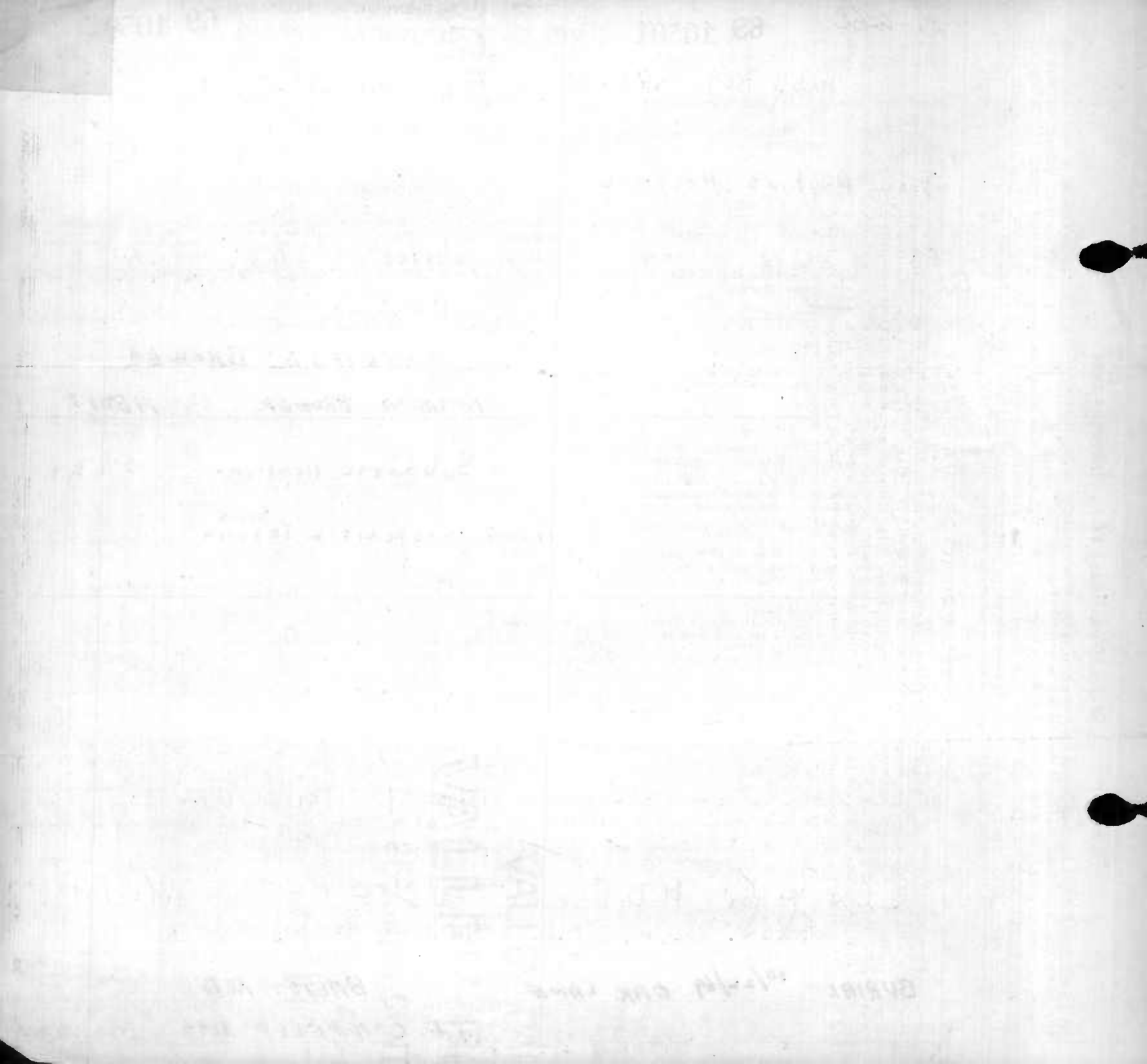


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burrs; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |                  |  |   |  |   |   |   |  |  |   |
|--|------------------|--|---|--|---|---|---|--|--|---|
| B-660 69 10501   |                  |  |   |  | CERTIFICATE OF DEATH  |   |   |  |  |   |
| BIRTH NO. 69-19178   |                  |  |   |  | REG. NO. 69 10501   |   |   |  |  |   |
| 1. NAME OF DECEASED<br>(Type or Print) BABY BOY BROWER   |                  |  |   |  | 2. DATE AND HOUR OF DEATH<br>10/21/69 250 AM  |   |   |  |  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                  |  |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)   |   |   |  |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>Johns Hopkins Hospital<br>33   |                  |  |   |  | A. STATE B. COUNTY<br>Maryland Baltimore  |   |   |  |  |   |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |                  |  |   |  | C. CITY OR TOWN<br>Baltimore  |   | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |   |
|  |                  |  |   |  | E. STREET AND NUMBER<br>7957 Lansdale Road  |   |   |  |  |   |
| 5. SEX<br>M  | 6. RACE<br>white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>10/18/69  | 9. AGE (In years last birthday)<br>2 1/2 yrs   | If Under 1 Yr. Months: Days: Hours: Min.  |   | If Under 24 Hrs. Min.   |  |  |   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                  |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br>Maryland   |   | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.  |  |  |   |
| 13. FATHER'S NAME  |                  |  |   |  | 14. MOTHER'S MAIDEN NAME<br>PATRICIA BROWER   |   |   |  |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No   |                  |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br>PATRICIA BROWER  |   | ADDRESS<br>ABOVE  |  |  |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                  |  |   |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>Subdural Hematoma<br>(B) <sup>BIRTH</sup> Thrombocytopenia + Trauma DUE TO, OR AS A CONSEQUENCE OF:<br>(C) |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 1/2 Ds. |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |                  |  |   |  |   |   |   |  |  |   |
| 19A. DATE OF OPERATION<br>2  |                  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br>YES  |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |   |  |  |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  |                  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |   |   |  |  |   |
| 22. I certify that (I) (this hospital) attended the deceased from 10/19 19 69 to 10/21 19 69, that (I) (we) last saw the deceased alive on 10/21 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                          |                  |  |   |  |   |   |   |  |  |   |
| 23A. SIGNATURE<br>Robert S. Zeiger M.D.  |                  |  |   |  | 23B. DATE SIGNED<br>10/21/69  |   |   | 23C. PHYSICIAN'S NAME (Type)<br>Robert S. Zeiger, M.D. |  |   |
| 23D. ADDRESS<br>The Johns Hopkins Hospital   |                  |  |   |  |   |   |   |  |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>BURIAL   |                  | 24B. DATE<br>10/22/69  |   | 24C. NAME of CEMETERY or CREMATORY<br>OAK LAWN |   | 24D. LOCATION (City, town, or county) (State)<br>BALTO. MD. |   |  |  |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br>OCT 27 1969   |                  | 25B. NAME OF REGISTRAR<br>Robert E. Taylor M.D.  |   | 25C. FUNERAL DIRECTOR<br>J.G. CONNELLY Sons    |   |   |   | ADDRESS<br>3rd floor                                   |  |   |





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |                                   |   |   | REG. NO. <b>69 10502</b>  |   |
|--|-----------------------------------|---|---|---|---|
| BIRTH NO. <b>S-462</b>   |                                   | 69 10502  |   | CERTIFICATE OF DEATH  |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>SELLERS, NETTIE Anastasia</b>  |                                   |   | 2. DATE AND HOUR OF DEATH<br><b>10-22-69 11:45 a.m.</b>   |   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                                   |   | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)<br>A. STATE <b>MD</b> B. COUNTY <b>BALTIMORE</b>  |   |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>46 730 Ashburton LUTHERAN HOSPITAL</b>  |                                   |   | C. CITY OR TOWN<br><b>Balto.</b>  |   | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |                                   |   | E. STREET AND NUMBER<br><b>5110 Greenwuch Ave</b>   |   |   |
| 5. SEX<br><b>F</b>   | 6. RACE<br><b>W</b>               | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10-6-88</b>  | 9. AGE (In years last birthday)<br><b>81</b>  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Baby Sitter</b>  |                                   | 10B. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (State or foreign Country)<br><b>Balto. Md.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |
| 13. FATHER'S NAME<br><b>William E. Riddell</b>   |                                   |   | 14. MOTHER'S MAIDEN NAME<br><b>Alice Frederick</b>  |   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>  |                                   | 16. SOCIAL SECURITY NO.<br><b>220-30-2635</b>   | 17. INFORMANT <b>Silver Spring, Md. 20902</b> ADDRESS<br><b>Mr. Edward L. Riddell 2905 Dawson Ave.</b>  |   |   |
| 18. <b>427.0 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b>  |                                   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>7 days.</b>  |   |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                                   |   | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiac Failure</b><br>(B) <b>Congenital Heart Failure -</b> DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <b>Dehydration and Uraemia</b> |   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                                   |   |   |   |   |
| 19A. DATE OF OPERATION<br><b>0</b>   |                                   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)<br><b>No</b>  |   |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)  |                                   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                      |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  |                                   | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |   | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10, 16, 1969</b> to <b>10, 22, 1969</b> , that (I) (we) lost saw the deceased alive on <b>10, 22, 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                                   |   |   |   |   |
| 23A. SIGNATURE<br><b>Zaher Ahmad Khan</b>  |                                   |   | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>   |   | 23B. DATE SIGNED<br><b>10, 22, 69</b>   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>ZAHABER AHMAD KHAN</b>  |                                   |   | 23D. ADDRESS<br><b>% Lutheran Hospital</b>  |   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 24B. DATE<br><b>Oct. 25, 1969</b> | 24C. NAME OF CEMETERY or CREMATORY<br><b>Loudon Park Cem.</b>   |   | 24D. LOCATION (City, town, or county) (State)<br><b>Balto. Md.</b>  |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 27 1969</b>  |                                   | 25B. NAME OF REGISTRAR<br><b>Robert L. Taylor, M.D.</b>   |   | 25C. FUNERAL DIRECTOR ADDRESS<br><b>Balto. Md. 21229</b><br><b>G. Truman Schwab 5151 Balto. National Pike</b> |   |

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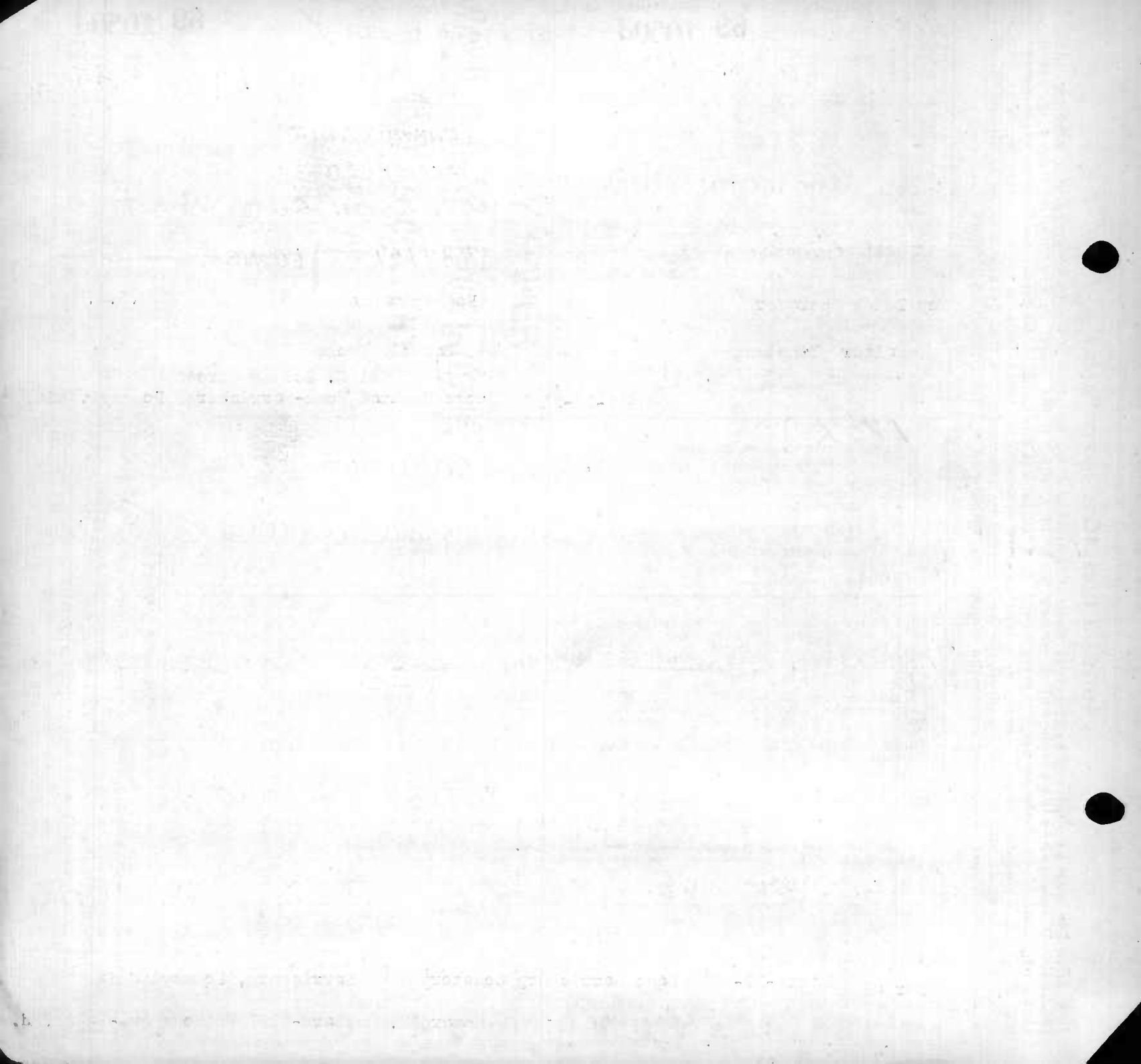
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CONFIDENTIAL

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |   |   |   |
|---|---|---|---|
| BALTIMORE CITY HEALTH DEPARTMENT  |   | REG. NO. <b>69 10503</b>  |   |
| M-460   |   | 69 10503  |   |
| BIRTH NO.   |   | 1. NAME OF DECEASED<br>(Type or Print) <b>Mary E. Miller</b>  |   |
| 2. DATE AND HOUR OF DEATH<br><b>10/24/69 9.55 A.M.</b>  |   | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>GOOD SAMARITAN HOSPITAL</b><br><b>45</b>   |   | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |   |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>PENNSYLVANIA</b><br>B. COUNTY <b>V-35</b>  |   | C. CITY OR TOWN<br><b>HARRISBURG</b>  |   |
| D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | E. STREET AND NUMBER<br><b>731 SOUTH 26th Street</b>  |   |
| 5. SEX<br><b>Female</b>   | 6. RACE<br><b>Caucasian</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>7/27/09</b>  |
| 9. AGE (In years last birthday)<br><b>60 yrs.</b>   |   | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.   |   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Key Punch Operator</b>  |   | 10B. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Pennsylvania</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Walter Yingling</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Rachel Owens</b>   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |   | 16. SOCIAL SECURITY NO.<br><b>180-26-5142</b>   |   |
| 17. INFORMANT <b>911 N. Second Street</b> ADDRESS<br><b>Reese Funeral Home-Harrisburg, Pennsylvania</b>   |   |   |   |
| 18. <b>180X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b><br>(A) IMMEDIATE CAUSE <b>Carcinomatosis</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <b>carcinoma of cervix</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 yrs</b><br><b>8 yrs.</b> |   |   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |   |   |   |
| 19A. DATE OF OPERATION<br><b>2</b>  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20A. AUTOPSY? (Yes or No)<br><b>YES</b>   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>NO</b> |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10/10/1969</b> to <b>10/24/1969</b> , that (I) (we) last saw the deceased alive on <b>10/23/69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.  |   |   |   |
| 23A. SIGNATURE<br><b>I. A. Orer M.D.</b>  |   | 23B. DATE SIGNED<br><b>10/24/69</b>   |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>I. A. Orer, M.D.</b>   |   | 23D. ADDRESS<br><b>The Good Samaritan Hospital</b>  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 24B. DATE<br><b>10-27-69</b>  | 24C. NAME OF CEMETERY or CREMATORY<br><b>East Harrisburg Cemetery</b>   | 24D. LOCATION (City, town, or county) (State)<br><b>Harrisburg, Pennsylvania</b>  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 27 1969</b>   | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher</b>   | 25C. FUNERAL DIRECTOR ADDRESS<br><b>Howard H. Hubbard-4107 Wilkens Ave, Balto. Md. 21229</b>  |   |



# FUNERAL DIRECTOR: IMPORTANT

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| BALTIMORE CITY HEALTH DEPARTMENT  |                         |  |   | Registered No. <b>69 10504</b>   |   |
|---|-------------------------|--|---|--|---|
| 7-260<br>BIRTH NO.  |                         | 69 10504   |   | CERTIFICATE OF DEATH   |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Wm. A. Fischer</b>  |                         |  | 2. DATE AND HOUR OF DEATH<br><b>10/20/69 7:40 A.M.</b>  |  |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>48 Md. General Hosp.</b>  |                         |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>2544</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Balto</b><br>D. STREET ADDRESS (If rural, give location)<br><b>4109 Townsend Ave</b> |  |   |
| 5. SEX<br><b>M</b>  | 6. RACE<br><b>White</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>Widowed</b>                             | 8. DATE OF BIRTH<br><b>10/17/28</b>   | 9. AGE (In years last birthday)<br><b>91</b>                             | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Salesman</b>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Food Industry</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>       |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |                         |  | 13. FATHER'S NAME<br><b>William A. Fischer</b>  |  |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |                         |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>   |  |   |
| 16. SOCIAL SECURITY NO.<br><b>212189823</b>   |                         | 17. INFORMANT<br><b>Oliver Bonaventure</b>   |   | ADDRESS<br><b>Same</b>   |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>395.01 Pulm. Atelectasis</b><br><b>Terminal Pneumonitis</b><br><b>Massive pleural effusion</b><br><b>CHF, ASCVD bilat.</b><br><b>RHD c aortic stenosis years</b><br><b>Organizing pulmon infarct @.</b><br><b>Bilat. pulm. emboli, old</b> |                         |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>&lt;1 month</b>  |  |   |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                         |  | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |   |
| 19A. DATE OF OPERATION<br><b>2</b>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No)<br><b>yes</b>                                  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>9/11</b> 19 <b>69</b> to <b>10/20</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>10/20</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                         |  |   |  |   |
| 23A. SIGNATURE<br><b>Robert Hawkins</b>   |                         |  |   | 23B. DATE SIGNED<br><b>10/20/69</b>                                      |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Robert Hawkins</b>   |                         |  |   | 23D. ADDRESS<br><b>Md. General Hosp.</b>                                 |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 24B. DATE<br><b>10/23/69</b>   |   | 24C. NAME OF CEMETERY or CREMATORY<br><b>Meadowridge Mem. Pk.</b>        |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>Howard Co., Md.</b>   |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 27 1969</b>  |   |  |   |
| 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher MD</b>  |                         | 25C. FUNERAL DIRECTOR<br><b>George J. Gonce</b>  |   |  |   |
| 25D. ADDRESS<br><b>4001 Ritchie Hwy.</b>  |                         |  |   |  |   |

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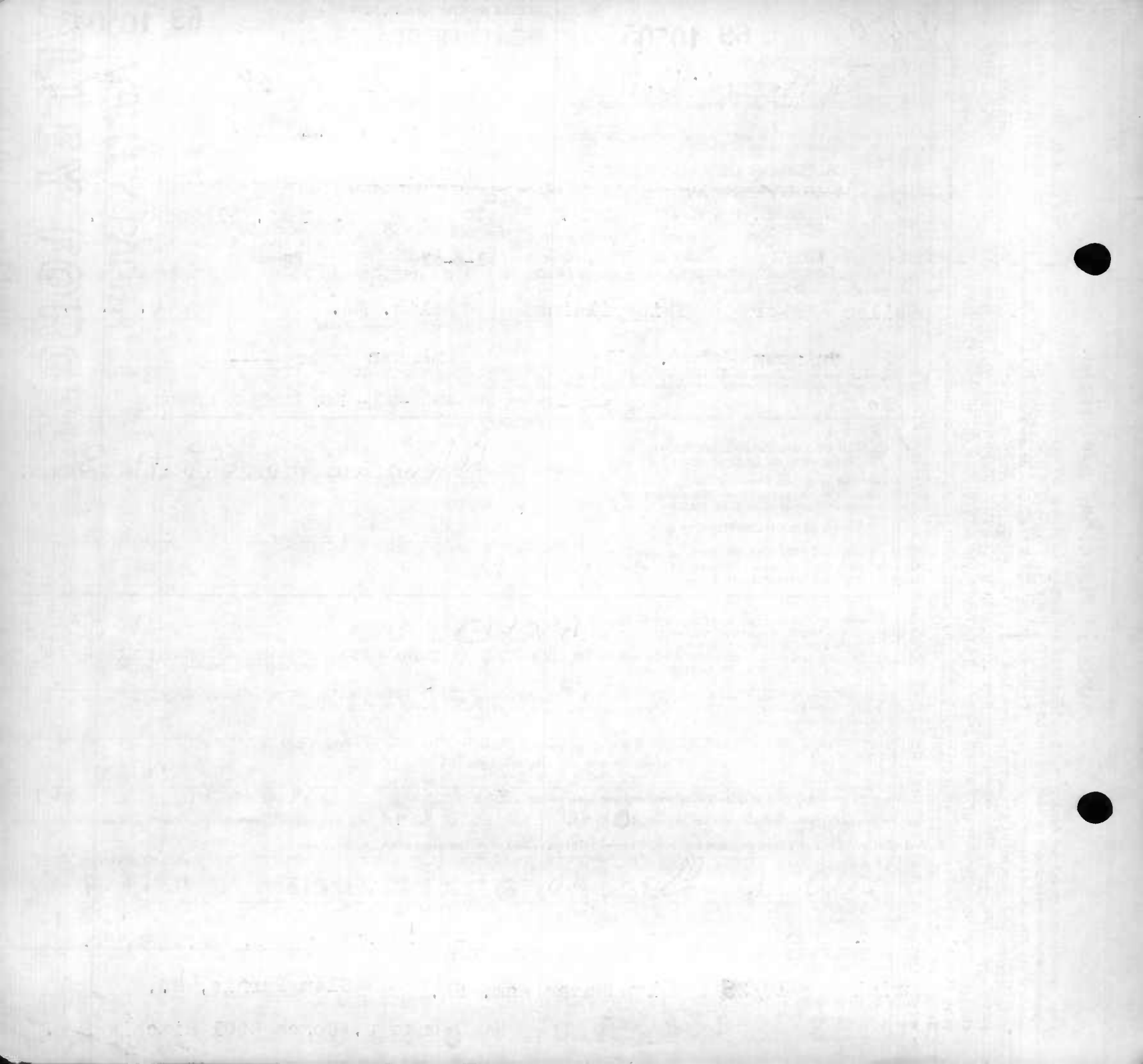
69 10505 CERTIFICATE OF DEATH

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                  |   |                            |   |  |  |  |
|---|------------------|---|----------------------------|---|--|--|--|
| V-400   |                  | 69 10505  |                            | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. 69 10505  |  |
| BIRTH NO.   |                  | 1. NAME OF DECEASED<br>(Type or Print) Jefferson A. Voll  |                            | 2. DATE AND HOUR OF DEATH<br>10-21-69 1:00 A.M.   |  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                  |   |                            | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)   |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>BALTIMORE CITY HOSPITALS<br>4940 EASTERN AVENUE<br>31 BALTIMORE, MARYLAND 21224   |                  |   |                            | A. STATE<br>MARYLAND<br>B. COUNTY<br>ANNE ARUNDEL C. CITY OR TOWN<br>GLEN BURNIE<br>D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>E. STREET AND NUMBER<br>BOX 501 Rt. 2 Mt. Pleasant Rd. |  |  |  |
| 5. SEX<br>MALE  | 6. RACE<br>WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>1-6-87 | 9. AGE (In years last birthday)<br>82   | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Hours: Min.   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Boiler Maker   |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>Shipbuilding   |                            | 11. BIRTHPLACE (State or foreign country)<br>Balto. Md.   |  | 12. CITIZEN OF WHAT COUNTRY?<br>U. S. A.                             |  |
| 13. FATHER'S NAME<br>Unknown John T. Voll   |                  |   |                            | 14. MOTHER'S MAIDEN NAME<br>Unknown Mary ----   |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No  |                  | 16. SOCIAL SECURITY NO.<br>213-05-6200A   |                            | 17. INFORMANT<br>RECORDS-BCH-4940 EASTERN AVENUE  |  |  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)<br>I<br>785X<br>Adenocarcinoma of Prostate 3 mos.  |                  |   |                            | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>20-30 yrs.           |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br>ASCVD   |                  |   |                            |   |  |  |  |
| 19A. DATE OF OPERATION<br>0   |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                            | 20A. AUTOPSY? (Yes or No)<br>NO   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                            | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |  |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)  |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                            | 21F. HOW DID INJURY OCCUR?  |  |  |  |
| 22. I certify that (H) (this hospital) attended the deceased from 8-1 19 69 to 10-21 19 69, that (H) (we) last saw the deceased alive on 10-20 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                  |   |                            |   |  |  |  |
| 23A. SIGNATURE<br>G. Winston Gragg, M.D.  |                  |   |                            | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>  |  | 23B. DATE SIGNED<br>10-21-69   |  |
| 23C. PHYSICIAN'S NAME (Type)<br>G. WINSTON GRAGG, MD  |                  |   |                            | 23D. ADDRESS<br>BCH-4940 EASTERN AVENUE, BALTIMORE, MD.   |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |                  | 24B. DATE<br>10/28/69   |                            | 24C. NAME OF CEMETERY or CREMATORY<br>Glen Haven Mem. Pk.   |  | 24D. LOCATION (City, town, or county) (State)<br>Glen Burnie, Md.    |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>OCT 27 1969  |                  | 25B. NAME OF REGISTRAR<br>Robert E. Taylor  |                            | 25C. FUNERAL DIRECTOR<br>George J. Gonce  |  | ADDRESS<br>4001 Ritchie Hwy.   |  |

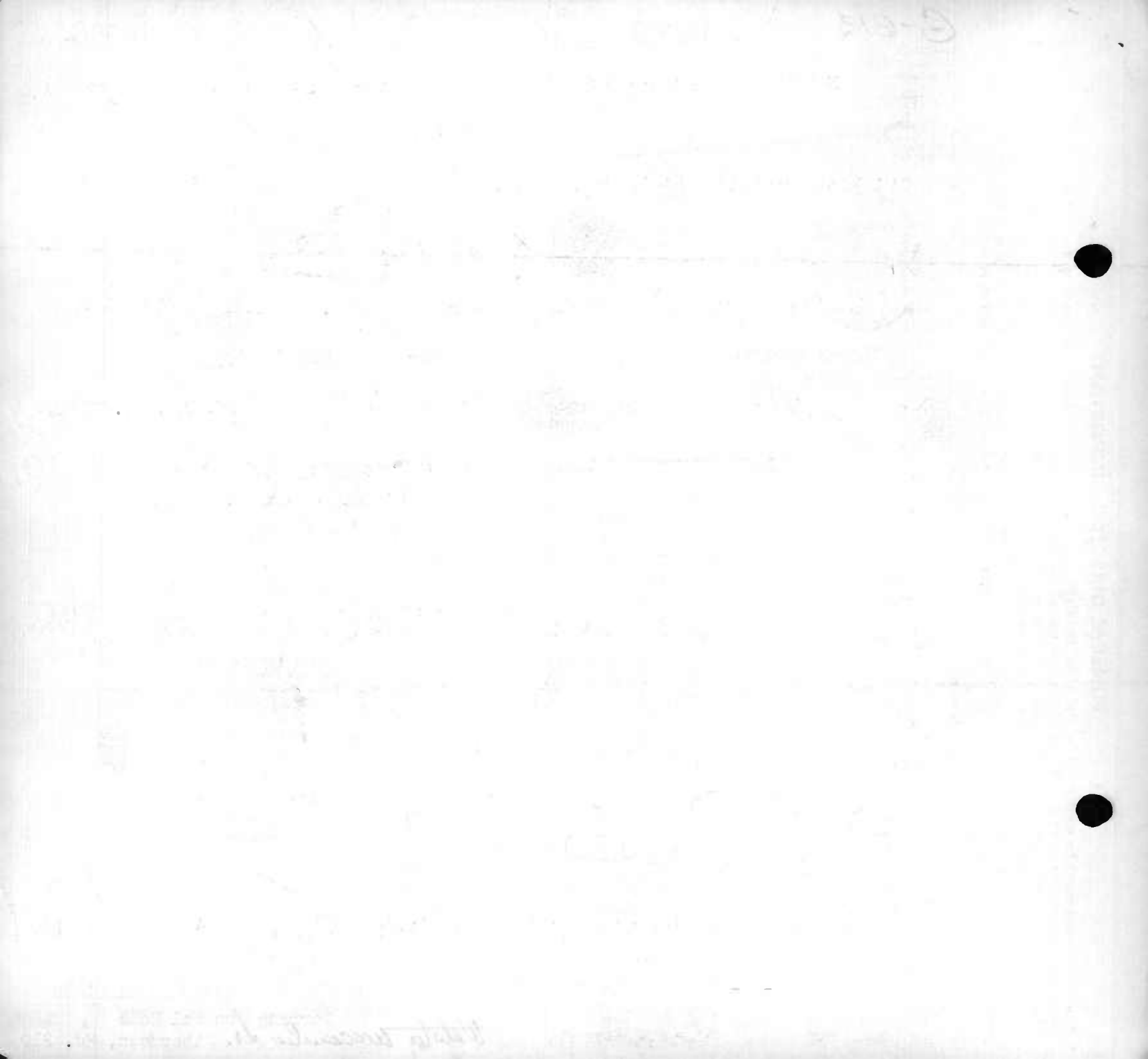




# FUNERAL DIRECTOR: IMPORTANT

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|   |                  |  |  |  |   |  |  |  |  |
|---|------------------|--|--|--|---|--|--|--|--|
| G-613   |                  | 69 10506   |  | BALTIMORE CITY HEALTH DEPARTMENT   |   | X  |  | REG. NO. 69 10506                          |  |
| BIRTH NO.   |                  | 1. NAME OF DECEASED<br>(Type or Print) <b>EDITH GRAFTON</b>  |  |  |   | 2. DATE AND HOUR OF DEATH<br><b>OCT. 23, 1969 4:30 A.M.</b>  |  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>35 CHURCH HOME AND HOSPITAL</b>   |                  |  |  |  |   | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>HARFORD</b><br>C. CITY OR TOWN <b>BEL AIR</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>E. STREET AND NUMBER <b>RT. 1 BOX 21</b> |  |  |  |
| 5. SEX <b>F</b>   | 6. RACE <b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>4/6/96</b>   | 9. AGE (In years last birthday) <b>73</b> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.  |  |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>School teacher (Retired) - Schools</b>  |                  |  |  | 10B. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Harford County, Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |  |
| 13. FATHER'S NAME<br><b>Thomas Burlington Grafton (D)</b>   |                  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Minnick (D)</b>                      |   |  |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no N/A</b>   |                  | 16. SOCIAL SECURITY NO.<br><b>212-38-4750</b>  |  | 17. INFORMANT<br><b>Edige Grafton</b>                                    |   | ADDRESS<br><b>Bel Air, Md. 21014</b>   |  |  |  |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>038.9 I Septicemic shock</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Pneumonia</b><br><b>LLL</b> |                  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Indef.</b>  |  |  |  |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>Severe malnutrition + dehydration. Indef.</b>  |                  |  |  |  |   |  |  |  |  |
| 19A. DATE OF OPERATION  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)  |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |  |  |  |  |
| 21D. TIME OF INJURY (APPROX.)   |                  | 21E. INJURY OCCURRED   |  | 21F. HOW DID INJURY OCCUR?   |   |  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>OCT. 23 19 69</b> to <b>OCT. 23 19 69</b> that (I) (we) last saw the deceased alive on <b>OCT. 23 19 69</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                  | 23A. SIGNATURE<br><b>Rolando A. Mendoza</b>  |  | 23B. DATE SIGNED<br><b>10/23/69</b>                                      |   |  |  |  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>ROLANDO A. MENDOZA, MD</b>   |                  | 23D. ADDRESS<br><b>100 N. Broadway St. (21231)</b>   |  |  |   |  |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                  | 24B. DATE<br><b>10-26-69</b>   |  | 24C. NAME of CEMETERY or CREMATORY<br><b>BAKERS CEMETERY</b>             |   | 24D. LOCATION (City, town, or county) (State)<br><b>ABERDEEN (HARFORD) MARYLAND</b>  |  |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 27 1969</b>   |                  | 25B. NAME OF REGISTRAR<br><b>Robert F. Taylor, MD</b>  |  | 25C. FUNERAL DIRECTOR<br><b>Tarring Funeral Home</b>                     |   | ADDRESS<br><b>Aberdeen, Md.</b>  |  |  |  |



# FUNERAL DIRECTOR: IMPORTANT

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|   |                     |  |  |   |  |   |                              |
|---|---------------------|--|--|---|--|---|------------------------------|
| C-160   |                     | 69 10507   |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. 69 10507   |                              |
| CERTIFICATE OF DEATH  |                     |  |  |   |  |   |                              |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Roy Cooper</b>  |                     |  |  | 2. DATE AND HOUR OF DEATH<br><b>10/23/69 1.0 P.M.</b>   |  |   |                              |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                     |  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>PENNSYLVANIA</b> B. COUNTY <b>V-35</b> |  |   |                              |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>34 Bon Secours Hospital</b>  |                     |  |  | C. CITY OR TOWN<br><b>GREENSBURG</b>  |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                   |                              |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |                     |  |  | E. STREET AND NUMBER<br><b>24 MEADOWBROOK AVE</b>   |  |   |                              |
| 5. SEX<br><b>M</b>  | 6. RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>1-10-84</b>  | 9. AGE (In years last birthday)<br><b>85</b> | If Under 1 Yr. Months: Days: Hours: Min.  | If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Farmer</b>  |                     | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><b>PENNSYLVANIA</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                              |
| 13. FATHER'S NAME<br><b>XXXXXXXXXXXX Albert Cooper</b>  |                     |  |  | 14. MOTHER'S MAIDEN NAME<br><b>XXXXXXXXXXXX Nancy Jane (Unknown)</b>  |  |   |                              |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                     | 16. SOCIAL SECURITY NO.<br><b>163-12-6593A</b>   |  | 17. INFORMANT<br><b>Mr. Donald Cooper, 24 Meadowbrook Ave. Pa.</b>  |  |   |                              |
| 18. CAUSE OF DEATH<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Rupture of Aneurysm of Aorta.</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.<br>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |                     |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>-</b>  |  |   |                              |
| 19A. DATE OF OPERATION<br><b>0</b>  |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                              |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |  |   |                              |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?  |  |   |                              |
| 22. I certify that (H) (this hospital) attended the deceased from <b>10.20.1969</b> to <b>10.23.1969</b> , that (H) (we) lost saw the deceased alive on <b>10.23.1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                     |  |  |   |  |   |                              |
| 23A. SIGNATURE<br><b>A. S. Lalani</b>   |                     |  |  | 23B. DATE SIGNED<br><b>10.23.69</b>   |  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |                              |
| 23C. PHYSICIAN'S NAME (Type)<br><b>A. S. LALANI. M.D.</b>   |                     |  |  | 23D. ADDRESS<br><b>Bon Secours Hospital, Baltimore MD, 21223</b>  |  |   |                              |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                     | 24B. DATE<br><b>10-25-69</b>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Mt. Joy Cemetery</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>Mt. Pleasant Township Westmoreland County, Penna.</b>                       |                              |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 27 1969</b>   |                     | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor</b>  |  | 25C. FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>  |  |   |                              |

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**FUNERAL DIRECTOR: IMPORTANT**

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| BALTIMORE CITY HEALTH DEPARTMENT  |              |  |                  | REG. NO. <b>69 10508</b>   |  |
|---|--------------|--|------------------|--|--|
| W-324 <b>69 10508</b>   |              | <b>CERTIFICATE OF DEATH</b>  |                  |  |  |
| BIRTH NO.   |              | 1. NAME OF DECEASED<br>(Type or Print)   |                  | 2. DATE AND HOUR OF DEATH  |  |
|   |              | <b>LLOYD E. WETZEL</b>   |                  | <b>October 22, 1969</b> <span style="float: right;"><i>2:30 P.M.</i></span>  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |              | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)    |                  |  |  |
|   |              | A. STATE <b>Maryland</b>   |                  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION  |              | C. CITY OR TOWN  |                  | D. INSIDE CITY LIMITS?   |  |
| <b>1810 Harmon Avenue<br/>Baltimore, Maryland</b>   |              | <b>Morrell Park</b>  |                  | <b>YES <input type="checkbox"/> NO <input type="checkbox"/></b>              |  |
| E. STREET AND NUMBER  |              |  |                  |  |  |
| <b>1810 Harmon Avenue</b>   |              |  |                  |  |  |
| 5. SEX  | 6. RACE      | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>               | 8. DATE OF BIRTH | 9. AGE (In years last birthday)  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| <b>Male</b>   | <b>White</b> | <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>     | <b>7-25-1887</b> | <b>82</b>  | <b>Retired Caulker</b>   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |              | 10B. KIND OF BUSINESS OR INDUSTRY  |                  | 11. BIRTHPLACE (State or foreign country)                                    |  |
| <b>Baltimore City</b>   |              | <b>Penna.</b>  |                  | <b>U.S.A.</b>  |  |
| 13. FATHER'S NAME   |              | 14. MOTHER'S MAIDEN NAME   |                  |  |  |
| <b>Unknown</b>  |              | <b>Unknown</b>   |                  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |              | 16. SOCIAL SECURITY NO.  |                  | 17. INFORMANT  |  |
| <b>No</b>   |              | <b>219-10-3081A</b>  |                  | <b>716 N. Hammonds Ferry<br/>Mr. Donald E. Wetzels, Linthicum, Md. 21090</b> |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |              | CAUSE OF DEATH   |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                 |  |
| <b>410.0 I</b>  |              | <b>Coronary occlusion.</b>   |                  | <b>seconds.</b>  |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  |              | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                      |                  |  |  |
| <b>ANTECEDENT CAUSES</b>  |              | <b>Anteriosclerotic heart disease</b>  |                  | <b>years.</b>  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |              | (B) DUE TO, OR AS A CONSEQUENCE OF:  |                  |  |  |
| <b>II</b>   |              | (C) DUE TO, OR AS A CONSEQUENCE OF:  |                  |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |              | <b>Chronic bronchitis &amp; pulmonary emphysema</b>                                      |                  | <b>years.</b>  |  |
| 19A. DATE OF OPERATION  |              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                  | 20A. AUTOPSY? (Yes or No)  |  |
| <b>0</b>  |              |  |                  | <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)   |              | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)     |  |
| <b>21D. TIME OF INJURY (APPROX.)</b>  |              | <b>21E. INJURY OCCURRED</b>  |                  | <b>21F. HOW DID INJURY OCCUR?</b>  |  |
| <b>(Month) (Day) (Year) (Hour)</b>  |              | <b>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></b> |                  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>9-12-1967</b> to <b>10-22-1969</b> , that (I) (we) last saw the deceased alive on <b>10-11-1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. |              |  |                  |  |  |
| 23A. SIGNATURE  |              | 23B. DATE SIGNED   |                  |  |  |
| <i>Cesar J. Pellerano</i>   |              | <b>10-22-69</b>  |                  |  |  |
| 23C. PHYSICIAN'S NAME (Type)  |              | 23D. ADDRESS   |                  |  |  |
| <b>Dr. Cesar J. Pellerano</b>   |              | <b>2436 Washington Blvd., Balto., Md.</b>  |                  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |              | 24B. DATE  |                  | 24C. NAME of CEMETERY or CREMATORY   |  |
| <b>Burial</b>   |              | <b>10-27-69</b>  |                  | <b>Loudon Park Cemetery</b>  |  |
| 24D. LOCATION (City, town, or county)   |              | 24E. LOCATION (State)  |                  |  |  |
| <b>Baltimore, Maryland</b>  |              |  |                  |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.   |              | 25B. NAME OF REGISTRAR   |                  | 25C. FUNERAL DIRECTOR  |  |
| <b>OCT 27 1969</b>  |              | <i>Robert E. Saylor, R.D.</i>  |                  | <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>                            |  |

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

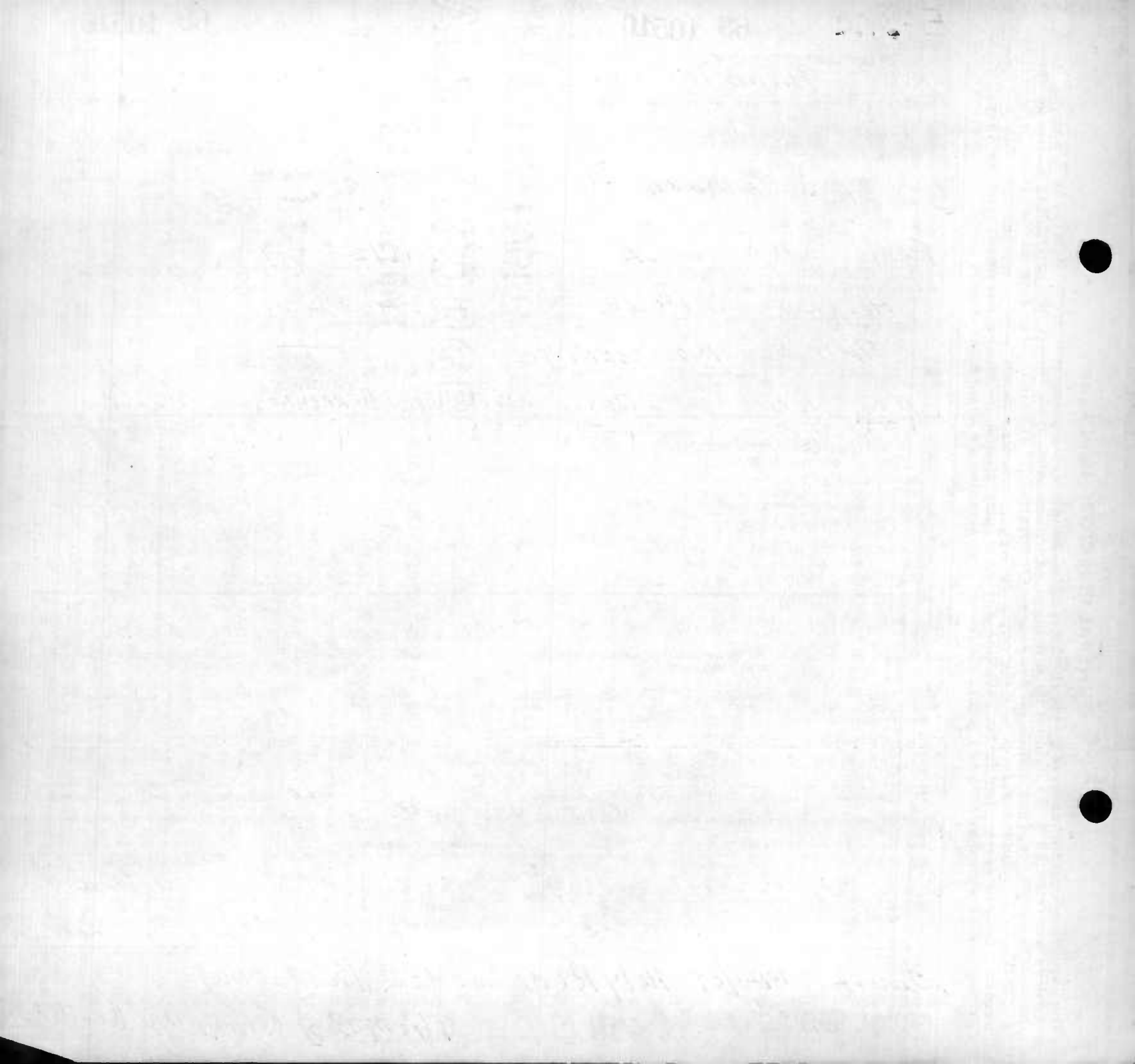
|   |                            |  |  |   |   |
|---|----------------------------|--|--|---|---|
| <div style="display: flex; justify-content: space-between;"> <span><b>D-520</b></span> <span><b>69 10509</b></span> </div>  |                            | <b>BALTIMORE CITY HEALTH DEPARTMENT</b><br><b>CERTIFICATE OF DEATH</b>   |  | <b>REG. NO. 69 10509</b>  |   |
| <b>BIRTH NO.</b><br>1. NAME OF DECEASED<br>(Type or Print) <b>DAN ZA RUTH</b>   |                            | <b>2. DATE AND HOUR OF DEATH</b><br><b>Oct-24 '69 16:10 A.M.</b>   |  |   |   |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><b>CERTIFICATE AMENDED</b><br>FULL NAME OF DECEASED: <b>DAN ZA RUTH</b><br>ADDRESS OR LOCATION: <b>Franklin Square Hospital 11-3-69</b><br><b>36</b>   |                            | <b>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</b><br>A. STATE: <b>Baltimore</b> B. COUNTY: <b>Maryland</b><br><b>00852-00</b><br><b>5. CITY OR TOWN</b> <b>Severn M.D.</b> <b>6. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br><b>7. STREET AND NUMBER</b> <b>Quartermile Road Box 356</b> |  |   |   |
| <b>5. SEX</b><br><b>F</b>   | <b>6. RACE</b><br><b>W</b> | <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>  | <b>8. DATE OF BIRTH</b> <b>4/10/1909</b> | <b>9. AGE (In years last birthday)</b> <b>60</b>                                | <b>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>House wife</b> |
| <b>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>House wife</b>  |                            | <b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>OWN HOME</b>   |  | <b>11. BIRTHPLACE (State or foreign country)</b> <b>Baltimore M.D.</b>          | <b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>  |
| <b>13. FATHER'S NAME</b> <b>William James Danza Buddenbohn</b>  |                            | <b>14. MOTHER'S MAIDEN NAME</b> <b>?</b>   |  |   |   |
| <b>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</b> <b>None</b>   |                            | <b>16. SOCIAL SECURITY NO.</b>   |  | <b>17. INFORMANT</b> <b>JAMES DANZA, SAME AS 4</b><br><b>ADDRESS</b>            |   |
| <b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>1899-01</b> <b>I</b><br><b>CAUSE OF DEATH</b> <b>wide spread cerebral and pulmonary metastases</b><br><b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>4 Months</b><br><b>(B) Hyper nephroma</b> <b>4 months</b><br><b>DUE TO, OR AS A CONSEQUENCE OF:</b><br><b>(C)</b> |                            | <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>  |  |   |   |
| <b>II</b><br><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>  |                            |  |  |   |   |
| <b>19A. DATE OF OPERATION</b> <b>✓</b>  |                            | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>  |  | <b>20A. AUTOPSY? (Yes or No)</b>  |   |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</b> <input type="checkbox"/>   |                            | <b>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</b>  |  | <b>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</b> |   |
| <b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)  |                            | <b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | <b>21F. HOW DID INJURY OCCUR?</b>   |   |
| <b>22. I certify that (I) (this hospital) attended the deceased from <u>Sept 25</u> 19 <u>69</u> to <u>Oct 24</u> 19 <u>69</u> and that (I) (we) last saw the deceased alive on <u>Oct 20</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>   |                            |  |  |   |   |
| <b>23A. SIGNATURE</b> <b>Naohiko Umesaki</b>  |                            |  |  | <b>23B. DATE SIGNED</b> <b>Oct 28 '69</b>                                       |   |
| <b>23C. PHYSICIAN'S NAME (Type)</b> <b>Naohiko Umesaki</b>  |                            | <b>23D. ADDRESS</b> <b>Franklin Square Hospital</b>  |  |   |   |
| <b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b>   |                            | <b>24B. DATE</b> <b>27 Oct 69</b>  |  | <b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>Glen Haven Mem.</b>                |   |
| <b>24D. LOCATION</b> <b>Glen Burnie Md.</b>   |                            | <b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>OCT 27 1969</b>  |  |   |   |
| <b>25B. NAME OF REGISTRAR</b> <b>Robert E. Taylor, M.D.</b>   |                            | <b>25C. FUNERAL DIRECTOR</b> <b>KIRKLEY F. H.</b>  |  |   |   |
| <b>25D. ADDRESS</b> <b>Glen Burnie</b>  |                            |  |  |   |   |

Birth Certificate A-47128 - 1909  
11-3-69 M.H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|--|---|--|
| <h2 style="margin: 0;">E-200</h2> <h2 style="margin: 0;">69 10510</h2> <h2 style="margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</h2> <h2 style="margin: 0;">CERTIFICATE OF DEATH</h2>   |  | REG. NO. <b>69 10510</b>  |  |
| BIRTH NO. _____  |  | 1. NAME OF DECEASED<br>(Type or Print) <b>ANNA THERESA EWASKA</b>   |  |
| 2. DATE AND HOUR OF DEATH<br><b>10-24-1969</b>   |  | M.  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><br><b>0031 S. CALHOUN ST</b>   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>MD</b> B. COUNTY <b>1902</b>                           |  |
| 5. CITY OR TOWN<br><b>BALTIMORE</b>  |  | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| E. STREET AND NUMBER<br><b>31 S. CALHOUN ST</b>  |  |   |  |
| 5. SEX<br><b>Fem</b>   | 6. RACE<br><b>wh</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9-21-1892</b>                                 |
| 9. AGE (In years last birthday)<br><b>77</b>   |  | If Under 1 Yr. Months: _____ Days: _____  | If Under 24 Hrs. Hours: _____ Min. _____                             |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>LITHUANIA</b>  |  | 12. CITIZEN OF WHAT COUNTRY? _____  |  |
| 13. FATHER'S NAME<br><b>MATTHIAS MOSKELUNVITE</b>  |  | 14. MOTHER'S MAIDEN NAME<br>_____   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>215054265</b>   |  |
| 17. INFORMANT<br><b>Mrs MARY DERRENBARGER</b>  |  | ADDRESS<br><b>5125 Greenway Rd</b>  |  |
| 18. <b>250.9 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Massive coronary occlusion</b>  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Q.S.C.V.D. Die later</b>   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>(A) IMMEDIATE CAUSE</b><br><b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b><br><b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>   |  |   |  |
| <b>II</b>  |  |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |   |  |
| 19A. DATE OF OPERATION<br><b>0</b>   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20A. AUTOPSY? (Yes or No)   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>1960</b> to <b>Oct 24</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>Oct 24</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |   |  |
| 23A. SIGNATURE<br><b>Stanley Ankudis</b>   |  | 23B. DATE SIGNED<br><b>10-24-69</b>   | 23C. PHYSICIAN'S NAME (Type)<br><b>STANLEY ANKUDIS</b>               |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>10/27/69</b>  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Holy Redeemer Cem</b>       |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baeta md</b>   |  | 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 27 1969</b>   |  |
| 25B. NAME OF REGISTRAR<br><b>Robert E. Kelly</b>   |  | 25C. FUNERAL DIRECTOR<br><b>J. Kennedy Inc</b>  |  |
| ADDRESS<br><b>1600 14th Ave</b>  |  |   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO.  |         | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO.                        |  |
|--|---------|---|--|---------------------------------|--|
| M-622  |         | 69 10511  |  | 69 10511                        |  |
| 1. NAME OF DECEASED<br>(Type or Print)   |         |   | 2. DATE AND HOUR OF DEATH  |                                 |  |
| RAYMUNDA MARQUES   |         |   | 10/23/69 6.40 PM M.  |                                 |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |         |   | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)    |                                 |  |
| PULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |         |   | A. STATE B. COUNTY   |                                 |  |
| HASINAI HOSPITAL   |         |   | Md 2755  |                                 |  |
|  |         |   | C. CITY OR TOWN  |                                 | D. INSIDE CITY LIMITS?   |
|  |         |   | Baltimore  |                                 | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |
|  |         |   | E. STREET AND NUMBER   |                                 |  |
|  |         |   | 8 Olmsted Green  |                                 |  |
| 5. SEX   | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>    | 8. DATE OF BIRTH   | 9. AGE (in years last birthday) | 10. If Under 1 Yr. Months Days   |
| F  | W       | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 7/27/04  | 65                              |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |         |   | 11. BIRTHPLACE (State or foreign country)  |                                 | 12. CITIZEN OF WHAT COUNTRY?   |
| Housekeeper  |         |   | Brazil   |                                 | U.S.A.   |
| 13. FATHER'S NAME  |         |   | 14. MOTHER'S MAIDEN NAME   |                                 |  |
| MANUEL DE OLIVEIRA MARQUES   |         |   | CATARINA VIERA   |                                 |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |         |   | 16. SOCIAL SECURITY NO.  |                                 | 17. INFORMANT ADDRESS  |
|  |         |   | 184-26-7653  |                                 | Fernando Marques 1529 W 36th St  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH   |         |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |                                 |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   |         |   | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                      |                                 |  |
| ANTECEDENT CAUSES  |         |   | Cerebrovascular accident 2-3 days  |                                 |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |         |   | (B) DUE TO, OR AS A CONSEQUENCE OF:  |                                 |  |
| II   |         |   | ASCVD  |                                 |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |         |   | (C) DUE TO, OR AS A CONSEQUENCE OF:  |                                 |  |
| 19A. DATE OF OPERATION   |         |   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                 | 20A. AUTOPSY? (Yes or No)  |
| 2  |         |   |  |                                 | yes  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |         |   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |                                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)  |         |   | 21E. INJURY OCCURRED   |                                 | 21F. HOW DID INJURY OCCUR?   |
| (APPROX.)  |         |   | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |                                 |  |
| 22. I certify that (I) (this hospital) attended the deceased from 10/22/69 19 to 10/23/69 19 that (I) (we) last saw the deceased alive on 10/23/69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |         |   |  |                                 |  |
| 23A. SIGNATURE   |         |   | 23B. DATE SIGNED   |                                 |  |
| 23C. PHYSICIAN'S NAME (Type)   |         |   | 23D. ADDRESS   |                                 |  |
| DONAL D. GAYNOR MD   |         |   |  |                                 |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |         | 24B. DATE   | 24C. NAME OF CEMETERY OR CREMATORY   |                                 | 24D. LOCATION (City, town, or county) (State)                            |
| Burial   |         | 27 Oct 1969   | St. Mary's (Hampton)   |                                 | Roland Ave. Balto., Md   |
| 25A. DATE REC'D BY HEALTH DEPT.  |         | 25B. NAME OF REGISTRAR  |  | 25C. FUNERAL DIRECTOR ADDRESS   |  |
| OCT 27 1969  |         | Deaf  |  | Burial Home 3631 Falls Rd       |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                   |   |  |  |   |  |  |
|---|-------------------|---|--|--|---|--|--|
| C-500   |                   | 69 10512  |  | BALTIMORE CITY HEALTH DEPARTMENT   |   | REG. NO. 69 10512  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>VERNON N. Conaway</b>   |                   |   |  | 2. DATE AND HOUR OF DEATH<br><b>10/23/69 8-30 A.M.</b>   |   |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>LUTHERAN Hosp.<br/>46 730 Ashburton St.<br/>Baltimore, Md. 21216</b>  |                   |   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Anne Arundel</b><br>C. CITY OR TOWN <b>Hanover</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>Box 402 Dorsey Road</b> |   |  |  |
| 5. SEX <b>M</b>   | 6. RACE <b>W.</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>5-14-13</b>  | 9. AGE (In years last birthday) <b>56</b> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Unemployed</b>  |                   | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Retired Handyman</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  |
| 13. FATHER'S NAME<br><b>Harry N. Conaway</b>  |                   |   |  | 14. MOTHER'S MARDEN NAME<br><b>Lillian Conaway</b>   |   |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                   | 16. SOCIAL SECURITY NO.<br><b>215-10-7426</b>   |  | 17. INFORMANT <b>R. Conaway</b> ADDRESS <b>Lillian Conaway Dorsey, Md.</b>   |   |  |  |
| 18. CAUSE OF DEATH<br>I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>Jaundice - Hepatic</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Coma</b><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br>- |                   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |  |  |
| 19A. DATE OF OPERATION<br><b>0 -</b>  |                   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-</b>  |  | 20A. AUTOPSY? (Yes or No)<br><b>No</b>   |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                     |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>-</b>  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>-</b>   |   |  |  |
| 21D. TIME OF INJURY (APPROX.)<br><b>-</b>   |                   | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?<br><b>-</b>   |   |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10-22-69</b> to <b>10-23-69</b> , that (I) (we) lost saw the deceased alive on <b>10-23-69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                   |   |  |  |   |  |  |
| 23A. SIGNATURE<br><b>KANTILAL J. SHAH M.D.</b>  |                   |   |  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>  |   | 23B. DATE SIGNED<br><b>10/23/69</b>  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>KANTILAL J. SHAH M.D.</b>  |                   |   |  | 23D. ADDRESS<br><b>Lutheran Hospital, Baltimore</b>  |   |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                   | 24B. DATE<br><b>10-27-69</b>  |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Zion Cemetery</b>   |   | 24D. LOCATION (City, town, or county) (State)<br><b>Washington Blvd. Howard Co., Md.</b> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 27 1969</b>   |                   | 25B. NAME OF REGISTRAR<br><b>Robert E. Hubbard</b>  |  | 25C. FUNERAL DIRECTOR ADDRESS<br><b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>   |   |  |  |





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

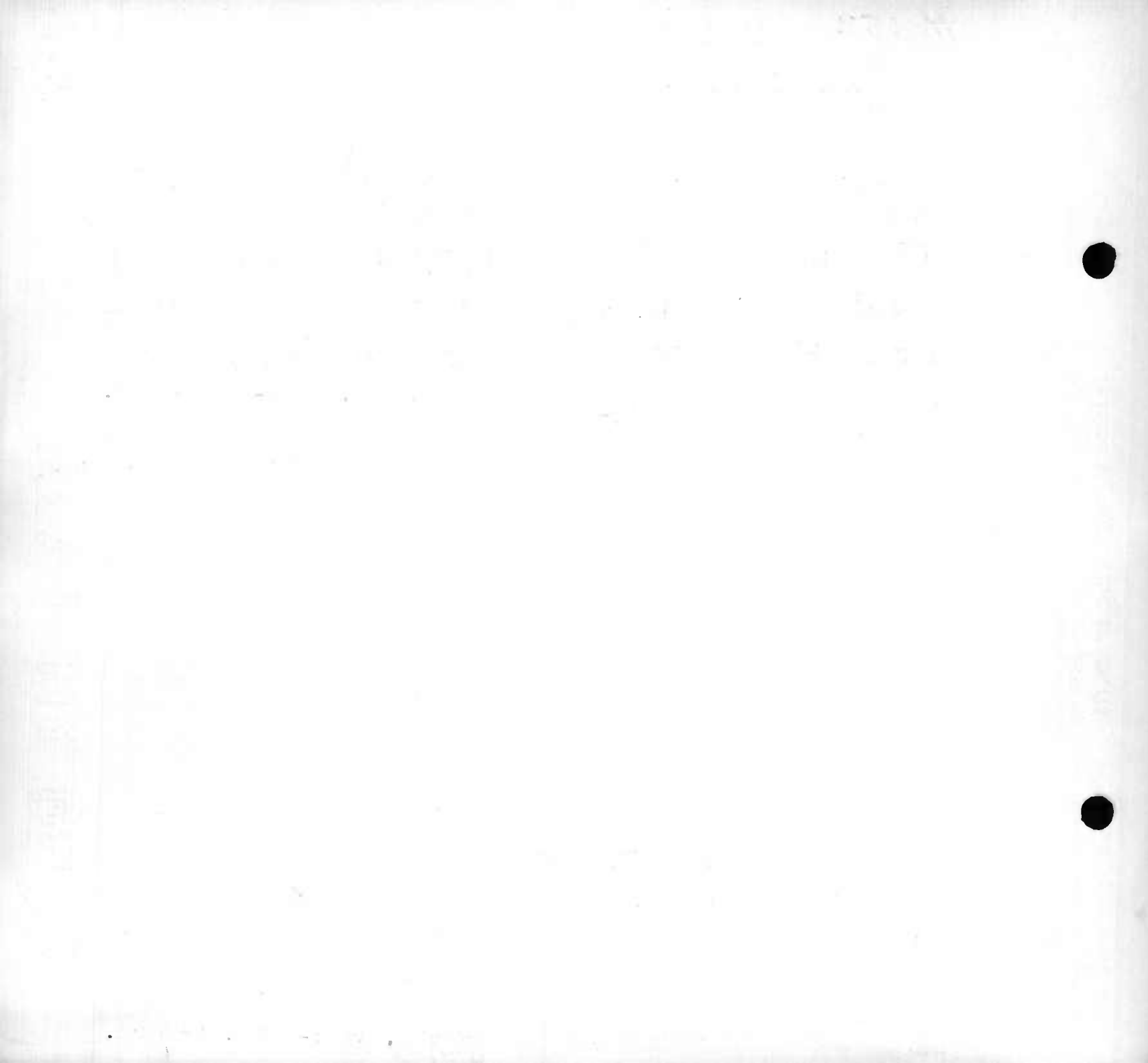
| W-623   |                     | BALTIMORE CITY HEALTH DEPARTMENT  |  | 69 10513   |   |
|---|---------------------|---|--|--|---|
| BIRTH NO.   |                     | 69 10513  |  | REG. NO. 69 10513  |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>WRIGHT, ROBERT E</b>  |                     |   | 2. DATE AND HOUR OF DEATH<br><b>10-23-69 7:25 AM</b>   |  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                     |   | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>1703</b> |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>UNIV of Md Hosp</b><br><b>38</b>  |                     |   | C. CITY OR TOWN<br><b>BALTO.</b>   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|   |                     |   | E. STREET AND NUMBER<br><b>343 ARGYLE AVE</b>  |  |   |
| 5. SEX<br><b>M</b>  | 6. RACE<br><b>B</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>7/3/04</b>  | 9. AGE (in years last birthday)<br><b>65</b>  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                     | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>RETIRED</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>USA</b>                    |   |
| 13. FATHER'S NAME<br><b>Not known</b>   |                     |   | 14. MOTHER'S MAIDEN NAME<br><b>Not known</b>   |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |                     | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS<br><b>WIFE, MILDRED WRIGHT</b>                       |   |
| 18. <b>162.1 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>CA of lung</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Atelectasis of lung</b> |                     |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>INFECTION of LUNG</b>  |                     |   |  |  |   |
| 19A. DATE OF OPERATION<br><b>10/23/69</b>   |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>CA of lung</b>   |  | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>                                     |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |   |
| 21D. TIME OF INJURY (APPROX.)<br><b>10-23-69 12:30 PM</b>   |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (1) (this hospital) attended the deceased from <b>10-16-69</b> to <b>10-23-69</b> that (1) (we) last saw the deceased alive on <b>10-23-69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.  |                     |   |  |  |   |
| 23A. SIGNATURE<br><b>Larry F. Halstead MD</b>   |                     |   |  | 23B. DATE SIGNED<br><b>10-23-69</b>  |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>GARY L. ROBERT</b>   |                     | 23D. ADDRESS<br><b>UNIV. Hosp.</b>  |  |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                     | 24B. DATE<br><b>10/29/69</b>  |  | 24C. NAME of CEMETERY or CREMATORY<br><b>National Cemetery</b>             |   |
| 24D. LOCATION<br><b>Baltimore Md</b>  |                     |   |  |  |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 27 1969</b>   |                     | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher, MD</b>   |  | 25C. FUNERAL DIRECTOR ADDRESS<br><b>Adolphus Halstead 1206 W North Ave</b> |   |

10/28/69 Address is 913 Argyle Ave.  
funeral home. CT

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| H-252   |  | 69 10514  |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. 69 10514   |  |
| BIRTH NO.   |  |   |  | 1. NAME OF DECEASED<br>(Type or Print) <b>ELSIE HAWKINS</b>   |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  |   |  | 2. DATE AND HOUR OF DEATH<br><b>OCTOBER 23, 1969 9<sup>50</sup> A.M.</b>  |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>UNIVERSITY OF MD HOSP</b>  |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>38</b>                         |  | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>A. STATE <b>MD</b><br>B. COUNTY <b>1403</b>                         |  | C. CITY OR TOWN<br><b>BALTIMORE</b>   |  |
| 5. SEX<br><b>F</b>  |  | 6. RACE<br><b>N</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>11/7/14</b>  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HW</b>  |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>HOME</b>  |  | 9. AGE (in years last birthday)<br><b>54</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>MD</b>                      |  |
| 13. FATHER'S NAME<br><b>LEE FITCHETT</b>  |  |   |  | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>   |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |  | 16. SOCIAL SECURITY NO.<br><b>213-14-2246</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>DELLA STEWART</b>  |  |   |  |
| 17. INFORMANT<br><b>John B. Hawkins-1833 Brunt St.</b>  |  | ADDRESS<br><b>HOSP CHART</b>  |  |   |  |   |  |
| 18. <b>590.0 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.)<br><b>CHRONIC PYELONEPHRITIS</b>   |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>&gt; 10 yrs</b>            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>&gt; 10 yrs</b>  |  |   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b>   |  | (B) DUE TO, OR AS A CONSEQUENCE OF:   |  | (C) DUE TO, OR AS A CONSEQUENCE OF:   |  |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |   |  |   |  |   |  |
| 19A. DATE OF OPERATION<br><b>0</b>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?        |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |   |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX)<br><b>1</b>   |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |   |  |
| 22. I certify that <del>(he)</del> (this hospital) attended the deceased from <b>OCT 12</b> 19 <b>69</b> to <b>OCT 23</b> 19 <b>69</b><br>that (I) <del>(we)</del> last saw the deceased alive on <b>OCT 23</b> 19 <b>69</b> and that (in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death. |  |   |  |   |  |   |  |
| 23A. SIGNATURE<br><b>Harvey Gordon MD</b>   |  | 23B. DATE SIGNED<br><b>OCT 23, 1969</b>   |  | 23C. PHYSICIAN'S NAME (Type)<br><b>MARVIN J. GORDON MD</b>  |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 24B. DATE<br><b>10/28/1969</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National Cemetery</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 27 1969</b>   |  | 25B. NAME OF REGISTRAR<br><b>Robert L. Taylor</b>   |  | 25C. FUNERAL DIRECTOR<br><b>Herbert E. Nutter-3035 W. North Ave.</b>  |  | ADDRESS   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                         |   |   |   |  |   |  |
|---|-------------------------|---|---|---|--|---|--|
| E-620   |                         | 69 10515  |   | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. 69 10515   |  |
| BIRTH NO.   |                         |   |   | 1   |  |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>MARY EURICE</b>   |                         |   |   | 2. DATE AND HOUR OF DEATH<br><b>OCTOBER 20, 1969 6:30 M.</b>  |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                         |   |   | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)   |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>90 Ashburton Nursing Home<br/>3520 Hiltm Road<br/>Baltimore, Md.</b>  |                         |   |   | A. STATE<br><b>Md.</b>  |  | B. COUNTY<br><b>Prince Georges 15-11</b>  |  |
|   |                         |   |   | C. CITY OR TOWN<br><b>Whitemarsh</b>  |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
|   |                         |   |   | E. STREET AND NUMBER  |  |   |  |
| 5. SEX<br><b>Female</b>   | 6. RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Nov. 30 1889</b> | 9. AGE (In years lost birthday)<br><b>79</b>  | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Hours: Min.  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   |  |
| 13. FATHER'S NAME<br><b>Unknown</b>   |                         |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>   |                         | 16. SOCIAL SECURITY NO.<br><b>218-05-6432A</b>  |   | 17. INFORMANT<br><b>Mrs. Louise C. Thompson</b>   |  | ADDRESS<br><b>Huntsville Alabama</b>  |  |
| 18. <b>412.3 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Arteriosclerotic heart disease</b><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>unknown</b>   |                         |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>unknown</b>  |  |   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,<br><b>II</b>   |                         |   |   |   |  |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |                         |   |   |   |  |   |  |
| 19A. DATE OF OPERATION<br><b>0</b>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |   | 21F. HOW DID INJURY OCCUR?  |  |   |  |
| 22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Oct. 8, 1969</b> to <b>Oct. 20, 1969</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>Oct. 17, 1969</b> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death. |                         |   |   |   |  |   |  |
| 23A. SIGNATURE<br><b>Abraham B. Hurwitz MD</b>  |                         |   |   | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |  | 23B. DATE SIGNED<br><b>Oct. 21, 1969</b>  |  |
| 23C. PHYSICIAN'S NAME (Type) <b>ABRAHAM B. HURWITZ, MD.</b>   |                         |   |   | 23D. ADDRESS<br><b>7501 LIBERTY ROAD, BALTIMORE, MD.</b>  |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 24B. DATE<br><b>Oct 23 '69</b>  |   | 24C. NAME OF CEMETERY or CREMATORY<br><b>Cedar Bluff Cem.</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>Annapolis Md</b>                          |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 27 1969</b>   |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Galt</b>   |   | 25C. FUNERAL DIRECTOR<br><b>Beall Funeral Home</b>  |  | ADDRESS<br><b>1212 West St. Anna.</b>   |  |

10/28 address coded to 3520 Hilton Rd.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| M-525   |  | 69 10516   |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | REG. NO. 69 10516   |  |
| BIRTH NO.   |  |  |  | 1. NAME OF DECEASED<br>(Type or Print) <b>ROSARIO MANGUNO</b>  |  |   |  |
| 2. DATE AND HOUR OF DEATH<br><b>10/19/69</b>  |  |  |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><b>University of Maryland Hospital</b>   |  |   |  |
| 4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>Prince Georges 66-00</b>  |  |  |  | 5. CITY OR TOWN<br><b>Hyattsville</b>  |  |   |  |
| 6. STREET AND NUMBER<br><b>6803 Riggs Rd</b>  |  |  |  | 7. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 5. SEX<br><b>M</b>  |  | 6. RACE<br><b>W</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>10/6/98</b>                                      |  |
| 9. AGE (In years lost birthday)<br><b>70</b>  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Office Worker</b> |  | 11. BIRTHPLACE (State or foreign country)<br><b>Louisiana</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                             |  |
| 13. FATHER'S NAME<br><b>Joseph Manguno</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Olivia Fowler</b>   |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes</b>  |  | 16. SOCIAL SECURITY NO.<br><b>700-12-3903</b>  |  | 17. INFORMANT<br><b>MRS. MYRTLE</b>  |  | ADDRESS   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><b>Staphylococcal Sepsis</b>  |  |  |  | CAUSE OF DEATH<br><b>Staphylococcal Sepsis</b>   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b>           |  |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Multiple Staph Abscesses</b>   |  |  |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Multiple Staph Abscesses</b>  |  | 3 months  |  |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>Multiple Myeloma</b>   |  |  |  | (B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>Probable Staph Endocarditis</b>  |  | 4 days  |  |
| 21. DATE OF OPERATION   |  |  |  | 22. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 23. AUTOPSY? (Yes or No)  |  |
| 24. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  |  |  | 25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 26. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 27. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |  |  |  | 28. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 29. HOW DID INJURY OCCUR?   |  |
| 30. I certify that (I) (this hospital) attended the deceased from <b>9/12/69</b> 19 to <b>10/19/69</b> 19<br>that (I) ( <del>we</del> ) last saw the deceased alive on <b>10/19</b> 19 <b>69</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 31. SIGNATURE<br><b>Richard A. Baum, D.D.</b>   |  |  |  | 32. DATE SIGNED<br><b>10/19/69</b>   |  | 33. PHYSICIAN'S NAME (Type)<br><b>Richard A. Baum, D.D.</b>             |  |
| 34. PHYSICIAN'S NAME (Type)<br><b>Richard A. Baum, D.D.</b>   |  |  |  | 35. ADDRESS<br><b>University of Maryland Hospital</b>  |  | 36. DATE REC'D BY HEALTH DEPT.<br><b>OCT 27 1969</b>                    |  |
| 37. NAME OF CEMETERY or CREMATORY<br><b>St. Elizabeth</b>   |  |  |  | 38. LOCATION (City, town, or county) (State)<br><b>Alexander</b>   |  | 39. FUNERAL DIRECTOR<br><b>Robert E. Taylor, D.D.</b>                   |  |
| 40. DATE REC'D BY HEALTH DEPT.<br><b>OCT 27 1969</b>  |  |  |  | 41. NAME OF REGISTRAR<br><b>Robert E. Taylor, D.D.</b>   |  | 42. FUNERAL DIRECTOR<br><b>Robert E. Taylor, D.D.</b>                   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |  |  |  | REG. NO. <b>69 10517</b>  |  |
|--|--|--|--|---|--|
| B-620 69 10517   |  |  |  | CERTIFICATE OF DEATH  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>JOHN BRISCOE</b>   |  | 2. DATE AND HOUR OF DEATH<br><b>10-25-69 12:10 P.M.</b>  |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br><b>South Baltimore Memorial Hospital<br/>3001 South Hanover St.<br/>Baltimore, Maryland 21230</b>  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Me.</b> B. COUNTY <b>2505</b>                       |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>South Baltimore Memorial Hospital<br/>3001 South Hanover St.<br/>Baltimore, Maryland 21230</b>   |  | C. CITY OR TOWN<br><b>Baltimore</b>  |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 5. SEX <b>M</b> 6. RACE <b>White</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>12-2-1911</b> 9. AGE (In years last birthday) <b>57 yrs.</b>              |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager</b>   |  | 10B. KIND OF BUSINESS OR INDUSTRY <b>Boston Metals Co</b>  |  | 11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>                                   |  |
| 13. FATHER'S NAME<br><b>John F. Briscoe Sr.</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Murphy</b>   |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>   |  | 16. SOCIAL SECURITY NO.<br><b>212-10-6549</b>  |  | 17. INFORMANT<br><b>Ida Briscoe - wife</b> ADDRESS <b>same</b>                                |  |
| 18. <b>412.2 I</b>   |  | CAUSE OF DEATH   |  |   |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., head failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  |  | (A) IMMEDIATE CAUSE <b>Poss. Intracerebral Hemorrhage</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(A) <b>chronic cor pulmonale stage</b>                   |  |   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |  | (B) <b>HASCD</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____   |  |   |  |
| II   |  |  |  |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |  |  |   |  |
| 19A. DATE OF OPERATION <b>2</b>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>                                 |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10-20</b> 19 <b>69</b> to <b>10-25</b> 19 <b>69</b> that (I) (we) last saw the deceased alive on <b>10-25</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |   |  |
| 23A. SIGNATURE<br><b>Virginia Y. Fausto, M.D.</b>  |  |  |  | 23B. DATE SIGNED<br><b>10-25-69</b>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>VIRGINIA Y. FAUSTO</b>  |  | 23D. ADDRESS<br><b>South Baltimore Memorial Hospital</b>   |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>10-29-69</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Holy Cross Cemetery</b>                              |  |
| 24D. LOCATION<br><b>Balto. 21225 Ind</b>   |  | 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 27 1969</b>  |  |   |  |
| 25B. NAME OF REGISTRAR<br><b>Robert E. [Signature]</b>   |  | 25C. FUNERAL DIRECTOR<br><b>2614 N. [Signature] 2200 Pennsylvania</b>  |  |   |  |

1613 Cereal St.

7

Wm. H. H. H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |  |  |   |  |   |  |   |  |
|--|--|--|--|---|--|---|--|---|--|
| 7-450  |  | 69 10518   |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | CERTIFICATE OF DEATH  |  | REG. NO. 69 10518   |  |
| BIRTH NO.  |  | 1. NAME OF DECEASED<br>(Type or Print) <b>CHARLES FALLIN</b>                                     |  |   |  | 2. DATE AND HOUR OF DEATH<br><b>10/24/69</b>  |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |  |  |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD</b> B. COUNTY <b>1403</b> |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION   |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>541 CUMBERLAND ST</b> |  |   |  | C. CITY OR TOWN<br><b>BALTO.</b>  |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 5. SEX<br><b>M</b>   |  | 6. RACE<br><b>C.</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>12/25/81</b>   |  | 9. AGE (In years last birthday) <b>87</b>   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>FARMER</b>   |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><b>VA.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?  |  |   |  |
| 13. FATHER'S NAME<br><b>?</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Easter</b>   |  |   |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |  |  |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><b>BRENA WARRINGTON</b>  |  |   |  |
|  |  |  |  |   |  | ADDRESS<br><b>2421 Woodbrook Av.</b>  |  |   |  |
| 18. <b>412.3 I</b>   |  | CAUSE OF DEATH   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH   |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial Infarction</b>              |  |   |  |   |  | <b>2 yr</b>   |  |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  |  | (B) <b>Arteriosclerotic Heart Disease</b>  |  |   |  |   |  | <b>5 yr</b>   |  |
| ANTECEDENT CAUSES  |  | (C) _____  |  |   |  |   |  |   |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  |  |  |   |  |   |  |   |  |
| II   |  |  |  |   |  |   |  |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |  |  |   |  |   |  |   |  |
| 19A. DATE OF OPERATION   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)         |  | 21C. WHERE DID INJURY OCCUR?  |  | (If in Baltimore City, give exact location)   |  |   |  |
| 21D. TIME OF INJURY (APPROX.)  |  | 21E. INJURY OCCURRED   |  | 21F. HOW DID INJURY OCCUR?  |  |   |  |   |  |
|  |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                |  |   |  |   |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10-23</b> 19 <b>67</b> to <b>10-24-69</b> 19 <b>69</b> , that (I) (we) lost saw the deceased alive on <b>10-24-69</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |   |  |   |  |   |  |
| 23A. SIGNATURE<br><b>Franklin Phillips MD</b>  |  |  |  | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>                             |  | 23B. DATE SIGNED<br><b>10/27/69</b>   |  |   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>G. Franklin Phillips MD</b>   |  |  |  | 23D. ADDRESS<br><b>558 McMechen St Balto MD</b>   |  |   |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 24B. DATE<br><b>10/29/69</b>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>REhoboth Cem.</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>REhoboth, VA.</b>   |  |   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>Oct 27 1969</b>  |  | 25B. NAME OF REGISTRAR<br><b>John E. [unclear]</b>   |  | 25C. FUNERAL DIRECTOR<br><b>Joseph J. Lock</b>  |  | ADDRESS<br><b>1304 N. Central Ave</b>   |  |   |  |

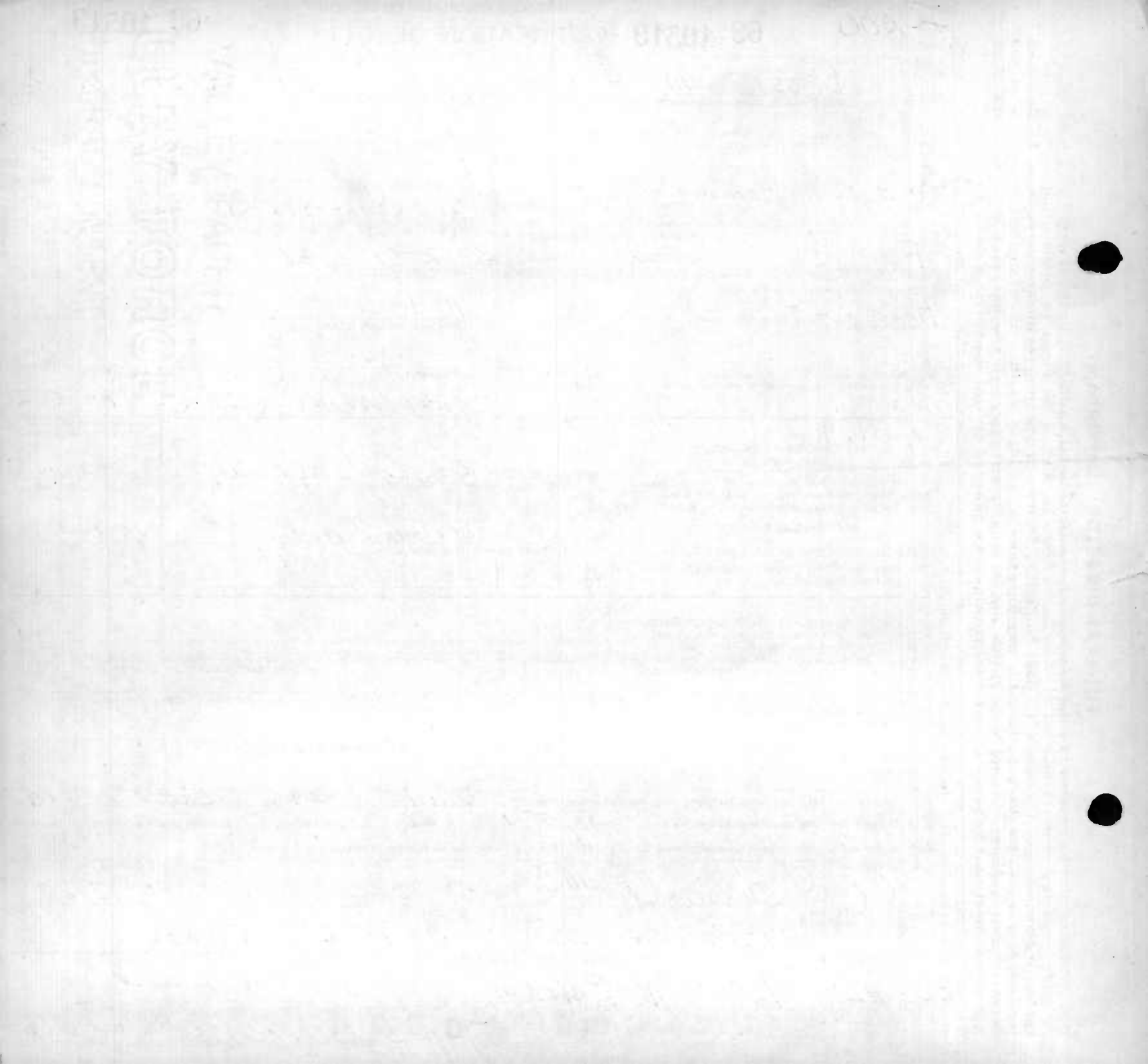
81701 83

81701 83

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| F-200  |  | 69 10519 |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | REG. NO. 69 10519 |  |
|--|--|----------|--|--|--|-------------------|--|
| BIRTH NO.  |  |          |  | 1. NAME OF DECEASED<br>(Type or Print) <b>BESSIE M. FOX</b>  |  |                   |  |
| 2. DATE AND HOUR OF DEATH<br><b>OCT 25, 1969 10 A.M.</b>   |  |          |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |                   |  |
| 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>A. STATE <b>MD</b> B. COUNTY <b>501</b>   |  |          |  | 5. SEX <b>F</b> 6. RACE <b>C</b>   |  |                   |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |          |  | 8. DATE OF BIRTH <b>3-12-01</b> 9. AGE (In years last birthday) <b>68</b>  |  |                   |  |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  |          |  | 11. BIRTHPLACE (State or foreign country) <b>MD</b>  |  |                   |  |
| 12. CITIZEN OF WHAT COUNTRY?   |  |          |  | 13. FATHER'S NAME <b>?</b>   |  |                   |  |
| 14. MOTHER'S MAIDEN NAME <b>?</b>  |  |          |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>   |  |                   |  |
| 16. SOCIAL SECURITY NO.  |  |          |  | 17. INFORMANT <b>Mildred Wheeler</b> ADDRESS <b>2304 G. CHASE ST</b>   |  |                   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>431.9 I</b> |  |          |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <b>Cerebral Hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <b>Arterio sclerosis</b> DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <b>10 minutes</b><br><b>10 years</b> |  |                   |  |
| 19. DATE OF OPERATION  |  |          |  | 20. AUTOPSY? (Yes or No)   |  |                   |  |
| 21. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |  |          |  | 22. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |                   |  |
| 23. PHYSICIAN'S NAME (Type) <b>A.C. BURWELL M.D.</b>   |  |          |  | 24. ADDRESS <b>1924 W. North Ave.</b>  |  |                   |  |
| 25. DATE REC'D BY HEALTH DEPT. <b>OCT 27 1969</b>  |  |          |  | 26. NAME OF REGISTRAR <b>Robert E. ...</b>   |  |                   |  |
| 27. FUNERAL DIRECTOR <b>Joseph A. ...</b>  |  |          |  | 28. ADDRESS <b>1304 N. Central Ave.</b>  |  |                   |  |

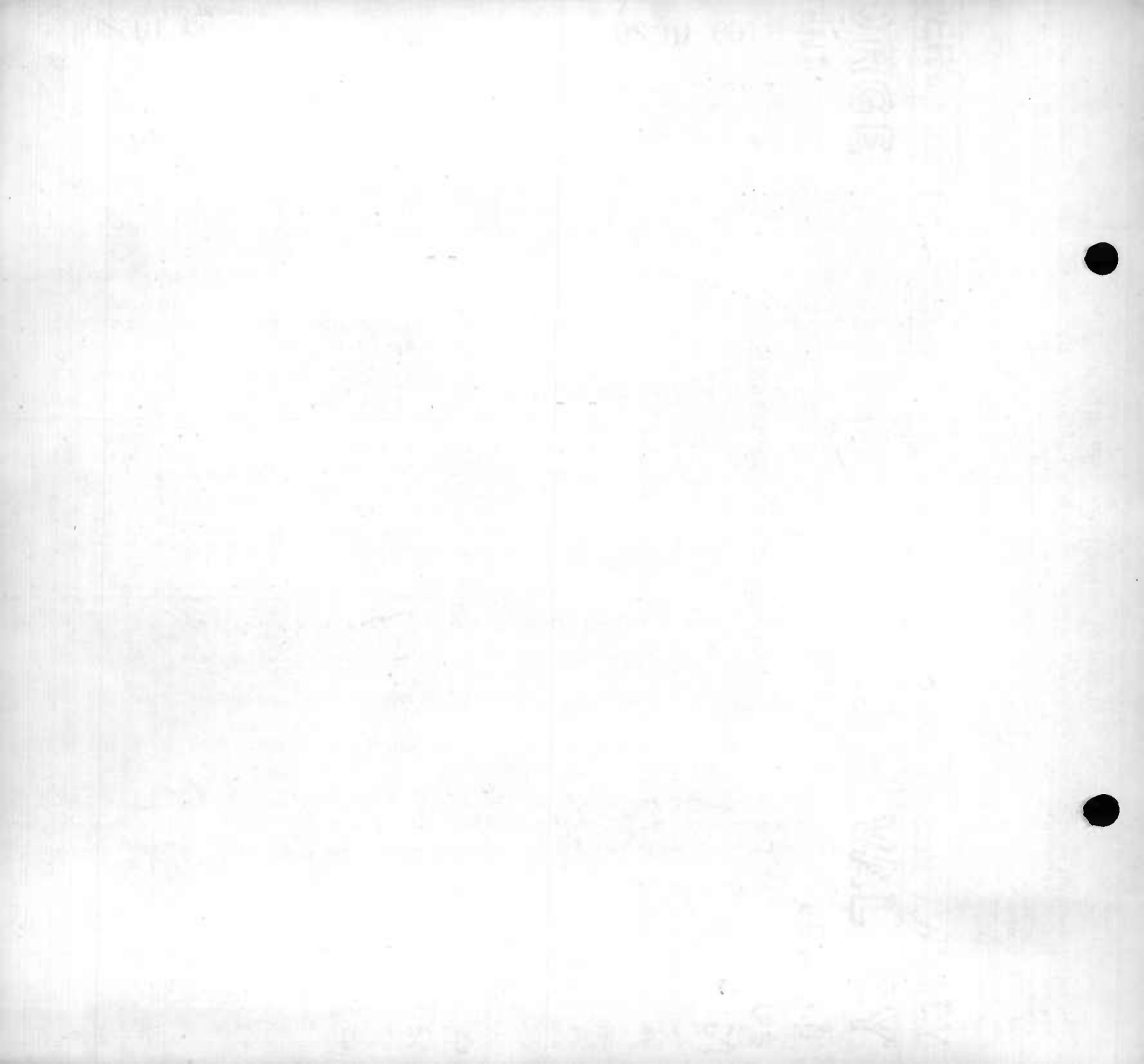




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

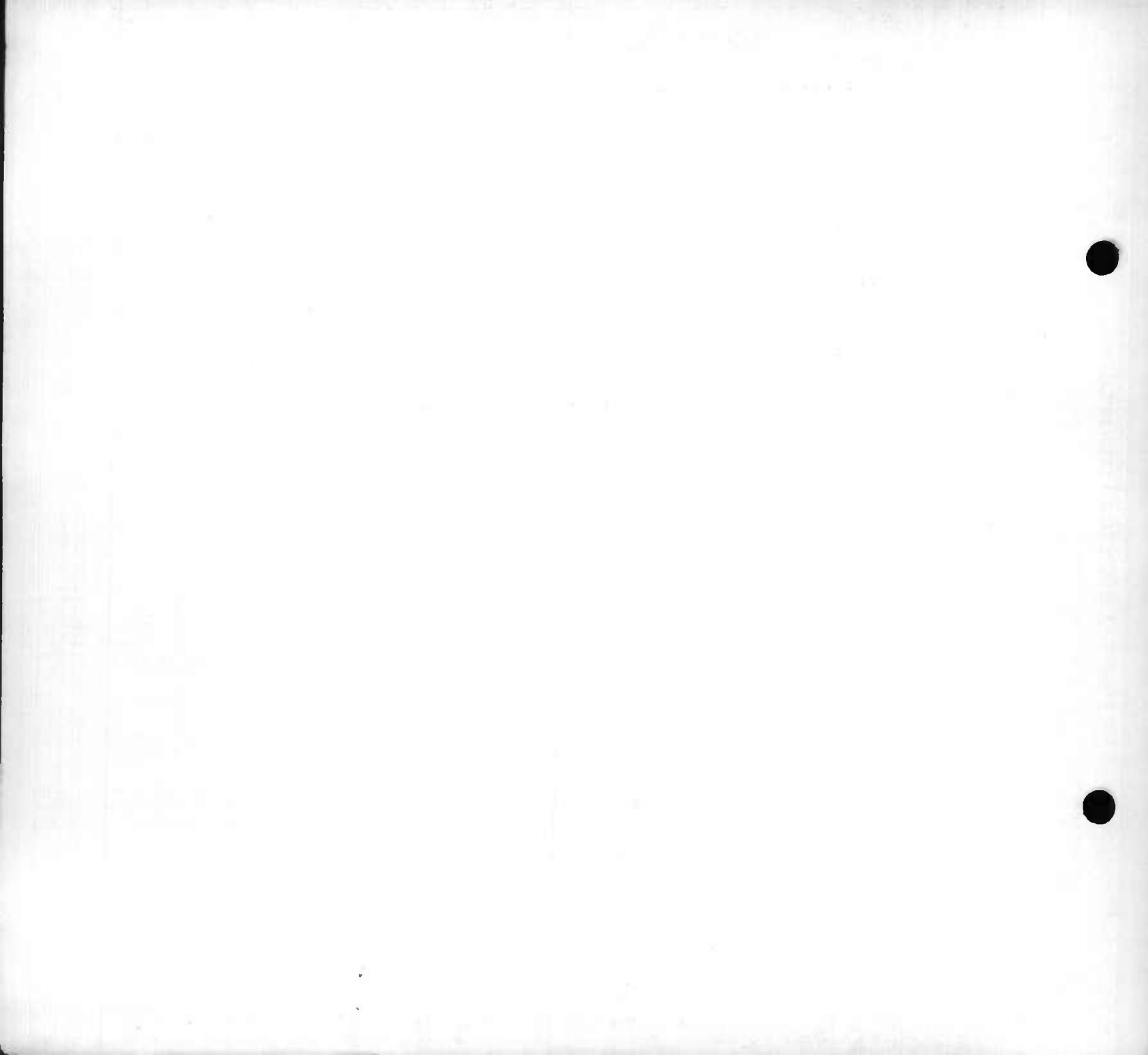
| BALTIMORE CITY HEALTH DEPARTMENT  |                              |   |  | REG. NO. <b>69 10520</b>   |   |
|---|------------------------------|---|--|--|---|
| <div style="display: flex; justify-content: space-between;"> <span><b>69 10520</b> CERTIFICATE OF DEATH</span> </div>   |                              |   |  |  |   |
| BIRTH NO. <b>X-534</b>  |                              |   |  |  |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Joseph Erwin Randall</b>  |                              |   | 2. DATE AND HOUR OF DEATH<br><b>10/22/69 9:10 a.m.</b>   |  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                              |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>46 99 Lutheran Hospital Baltimore, Maryland (DOA)</b>  |                              |   | A. STATE <b>Maryland</b><br>B. COUNTY <b>1605</b>  |  |   |
|   |                              |   | C. CITY OR TOWN<br><b>Baltimore</b>  |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|   |                              |   | E. STREET AND NUMBER<br><b>2413 W. Mosher Street</b>   |  |   |
| 5. SEX<br><b>M</b>  | 6. RACE<br><b>N</b>          | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5-8-07</b>  | 9. AGE (In years last birthday)<br><b>62</b>                                   | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Equipment Operator</b>  |                              | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                   |   |
| 13. FATHER'S NAME<br><b>Stephen E. Randall</b>  |                              |   | 14. MOTHER'S MAIDEN NAME<br><b>Betty Wiseman</b>   |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes WW II</b>  |                              | 16. SOCIAL SECURITY NO.<br><b>578-03-6415</b>   |  | 17. INFORMANT<br><b>Mrs. Eleanor A. Randall 2413 W. Mosher St.</b>             |   |
| 18. <b>410.9 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Coronary occlusion</b>   |                              |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>?</b>   |  |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                              |   | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>Coronary occlusion</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF: |  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>DOA Lutheran Hosp. Med. examiner notified</b>  |                              |   |  |  |   |
| 19A. DATE OF OPERATION<br><b>0 none</b>   |                              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><b>no</b>   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |                              | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)       |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                              | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Oct 14 1969</b> to <b>Oct 22 1969</b> , that (I) (we) last saw the deceased alive on <b>Oct 17, 1969</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. <b>Lutheran Hosp. Emergency</b> |                              |   |  |  |   |
| 23A. SIGNATURE<br><b>George McDonald MD</b>   |                              |   | 23B. DATE SIGNED   |  | 23C. PHYSICIAN'S NAME (Type)<br><b>Dr. George Mc Donald</b>                                   |
| 23D. ADDRESS<br><b>844 N. Carey Street</b>  |                              |   |  |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 24B. DATE<br><b>10/20/69</b> | 24C. NAME of CEMETERY or CREMATORY<br><b>Baltimore National Cem</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>    |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 27 1969</b>   |                              | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher, MD</b>   |  | 25C. FUNERAL DIRECTOR ADDRESS<br><b>Nutter Funeral Home 3035 W. North Ave.</b> |   |



# FUNERAL DIRECTOR: IMPORTANT

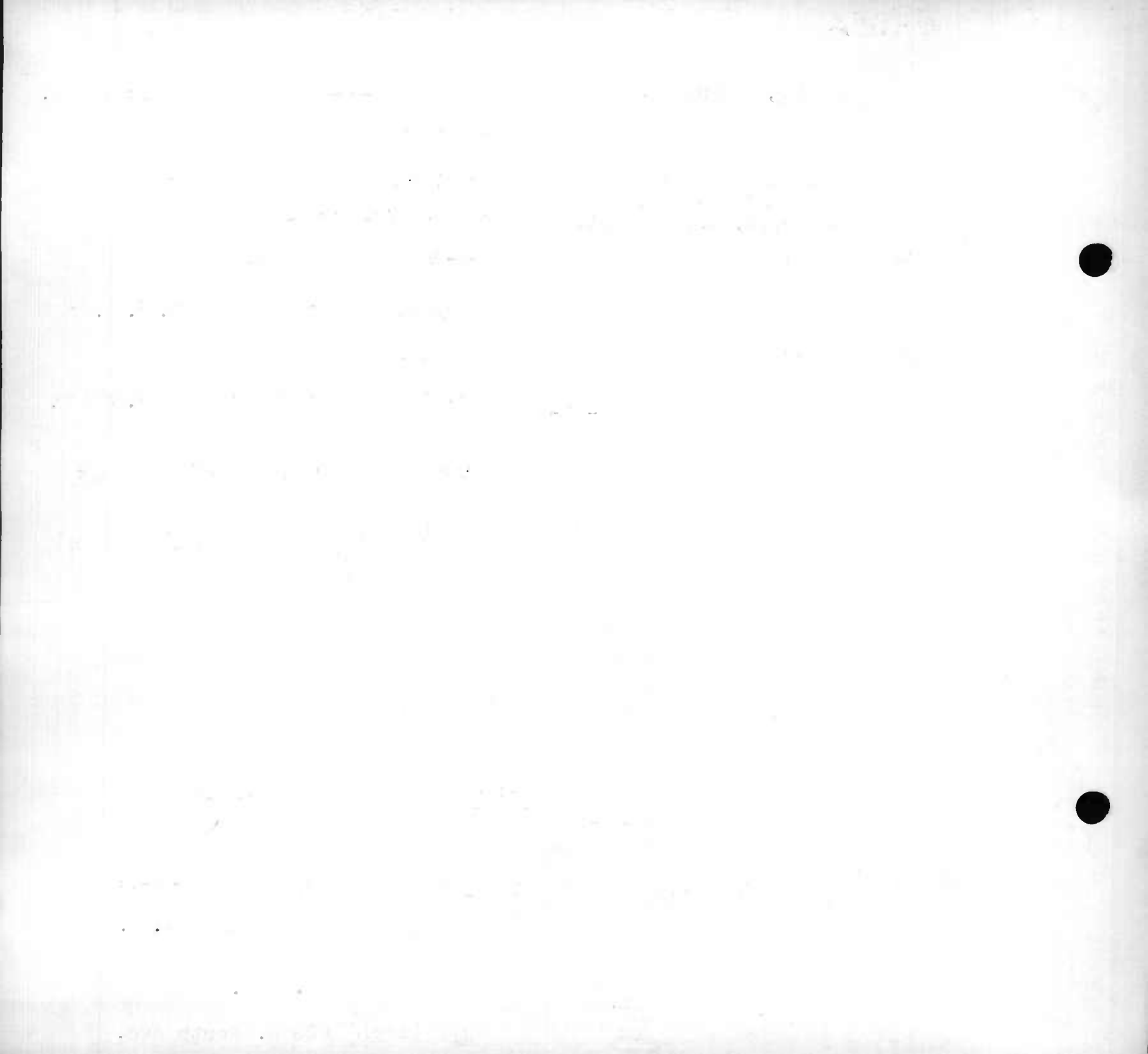
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|--|--|--|
| BALTIMORE CITY HEALTH DEPARTMENT   |  | REG. NO. <b>69 10521</b>   |  |
| BIRTH NO. <b>250</b>   |  | 69 10521 <b>CERTIFICATE OF DEATH</b>   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>EARSY JACKSON</b>  |  | 2. DATE AND HOUR OF DEATH<br><b>10-24-69 1:15 A.M.</b>   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br><b>MARYLAND GEN. HOSPITAL</b>  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>212/7 1601</b> |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>MARYLAND GEN. HOSPITAL</b>  |  | C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>              |  |
| 5. SEX <b>M</b> 6. RACE <b>C</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | E. STREET AND NUMBER <b>921 N. CARROLLTON AVE.</b>   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>   |  | 8. DATE OF BIRTH <b>6-22-1905</b> 9. AGE (In years last birthday) <b>64</b>  |  |
| 10B. KIND OF BUSINESS OR INDUSTRY <b>WALAC FLOOR SANDER</b>  |  | 11. BIRTHPLACE (State or foreign country) <b>MISSISSIPPI</b>   |  |
| 13. FATHER'S NAME <b>RALPH JACKSON</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>   |  | 16. SOCIAL SECURITY NO. <b>212-10-1771</b>   |  |
| 17. INFORMANT <b>WIFE CECILIA JACKSON</b>  |  | ADDRESS <b>SAME</b>  |  |
| 18. <b>412.31</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><b>Coronary Heart Failure 20</b>  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>MONTHS</b>  |  |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Arteriosclerotic Heart disease</b><br><b>YEARS</b>                          |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>II</b>  |  | (B) DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C)<br><br>   |  |
| 19A. DATE OF OPERATION <b>10-23-69</b>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Coronary artery disease</b>  |  |
| 20A. AUTOPSY? (Yes or No) <b>NO</b>  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  |
| 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10-23-69</b> to <b>10-24-69</b> that (I) (we) last saw the deceased alive on <b>10-26-69</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |
| 23A. SIGNATURE <b>Angelina A. Topacio</b>  |  | 23B. DATE SIGNED <b>10-24-69</b>   |  |
| 23C. PHYSICIAN'S NAME (Type) <b>ANGELINA A. TOPACIO</b>  |  | 23D. ADDRESS <b>MARYLAND GEN. HOSPITAL</b>   |  |
| 24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>  |  | 24B. DATE <b>10/29/69</b>  |  |
| 24C. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>  |  | 24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>  |  |
| 25A. DATE REC'D BY HEALTH DEPT. <b>OCT 27 1969</b>   |  | 25B. NAME OF REGISTRAR <b>Robert E. Taber</b>  |  |
| 25C. FUNERAL DIRECTOR <b>Nutter Funeral Home</b>   |  | ADDRESS <b>3035 W. North Ave.</b>  |  |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|--|--|--|
| BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. <b>69 10522</b>   |  |
| W-352   |  | 69 10522 CERTIFICATE OF DEATH  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Whiting, William H.</b>   |  | 2. DATE AND HOUR OF DEATH<br><b>10-23-69 11:35 A. M.</b>   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br><b>Provident, Hospital<br/>1415 Divison Street<br/>Baltimore, Maryland 21213</b>  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>1204</b> |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>39 Provident, Hospital<br/>1415 Divison Street<br/>Baltimore, Maryland 21213</b>   |  | C. CITY OR TOWN <b>Baltimore</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |
| 5. SEX <b>Male</b> 6. RACE <b>Negro</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <b>9-8-05</b> 9. AGE (In years last birthday) <b>64</b>   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>   |  | 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |  |
| 10B. KIND OF BUSINESS OR INDUSTRY   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>   |  |
| 13. FATHER'S NAME <b>William Whiting</b>  |  | 14. MOTHER'S MAIDEN NAME <b>Florence Thomas</b>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>  |  | 16. SOCIAL SECURITY NO. <b>722-16-1115</b>   |  |
| 17. INFORMANT <b>Mrs. Florence Prince-Mother</b>  |  | ADDRESS <b>442 E. 23rd St</b>  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>CVA due to HASCVD</b>  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Post-OP Lobectomy Bronchopneumonia</b>   |  | (B) DUE TO, OR AS A CONSEQUENCE OF: <b>1 yr</b>  |  |
| (C) _____   |  | _____  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |  |  |
| 19A. DATE OF OPERATION <b>9-25-69</b>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20A. AUTOPSY? (Yes or No) <b>No</b>   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |  |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>9-25-69</b> to <b>10-23-69</b> that (I) (we) last saw the deceased alive on <b>10-23-69</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |
| 23A. SIGNATURE <b>Eligah Skunder</b>  |  | 23B. DATE SIGNED <b>10-23-69</b>   |  |
| 23C. PHYSICIAN'S NAME (Type) <b>Eligah Skunder</b>  |  | 23D. ADDRESS <b>1415 Divison Street Baltimore, M., D.</b>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 24B. DATE <b>10/27/69</b>  |  |
| 24C. NAME OF CEMETERY OR CREMATORY <b>Mt Auburn Cemetery</b>  |  | 24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>   |  |
| 25A. DATE REC'D BY HEALTH DEPT. <b>Nov 27 1969</b>  |  | 25B. NAME OF REGISTRAR <b>Wm C March</b>   |  |
| 25C. FUNERAL DIRECTOR <b>Wm C March</b>   |  | ADDRESS <b>928 E. North Ave.</b>   |  |



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                            |  |   | REG. NO. <b>69 10523</b>  |
|---|----------------------------|--|---|---|
| <b>BIRTH NO.</b><br><b>1. NAME OF DECEASED</b><br>(Type or Print) <b>Kasinskas Katherine</b>  |                            | <b>2. DATE AND HOUR OF DEATH</b><br><b>October 25, 1969</b>  |   |   |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><br><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><br><b>Maryland General Hospital</b><br><b>48</b>  |                            | <b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)<br><b>A. STATE</b> <b>Maryland</b> <b>B. COUNTY</b><br><br><b>C. CITY OR TOWN</b> <b>Baltimore</b> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br><br><b>E. STREET AND NUMBER</b><br><b>432 Homeland Ave.</b> |   |   |
| <b>5. SEX</b><br><b>F</b>   | <b>6. RACE</b><br><b>W</b> | <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>  | <b>8. DATE OF BIRTH</b><br><b>11/22/82</b>        | <b>9. AGE</b> (In years last birthday)<br><b>87</b>                             |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                            | <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>Lithuania</b>   |   |   |
| <b>13. FATHER'S NAME</b><br><b>Zardeskas, Simon</b>   |                            | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Klinauskas</b>   |   |   |
| <b>15. Was Deceased Ever in U. S. Armed Forces?</b><br>(Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>   |                            | <b>16. SOCIAL SECURITY NO.</b><br><b>216-09-2140</b>   |   | <b>17. INFORMANT</b><br><b>Frank Lucas</b>                                      |
| <b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br><b>412.31</b><br><b>CAUSE OF DEATH</b><br><b>Arteriosclerotic Heart Disease with old Myocardial Infarction</b>                           |                            | <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b><br><b>44-5</b>   |   |   |
| <b>II</b><br><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>  |                            |  |   |   |
| <b>19A. DATE OF OPERATION</b><br><b>0</b>   |                            | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>  |   | <b>20A. AUTOPSY?</b> (Yes or No)<br><b>No</b>                                   |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>   |                            | <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) |
| <b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)<br>(APPROX.)   |                            | <b>21E. INJURY OCCURRED</b><br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |   | <b>21F. HOW DID INJURY OCCUR?</b>   |
| <b>22. I certify that (I) (this hospital) attended the deceased from</b> <b>May 1965</b> <b>to Oct. 1969</b> , <b>that (I) last saw the deceased alive on</b> <b>June 14, 1969</b> <b>and that in (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b> |                            |  |   |   |
| <b>23A. SIGNATURE</b><br><b>Wm. H. Kammer, Jr.</b>  |                            |  | <b>23B. DATE SIGNED</b><br><b>27 Oct. 69</b>      |   |
| <b>23C. PHYSICIAN'S NAME</b> (Type)<br><b>Wm. H. Kammer, Jr.</b>  |                            |  | <b>23D. ADDRESS</b><br><b>6011 York Rd. 21212</b> |   |
| <b>24A. BURIAL CREMATION, REMOVAL</b> (Specify)<br><b>Burial</b>  |                            | <b>24B. DATE</b><br><b>10/28/69</b>  |   | <b>24C. NAME OF CEMETERY or CREMATORY</b><br><b>Most Holy Redeemer</b>          |
| <b>24D. LOCATION</b> (City, town, or county) (State)<br><b>Baltimore, Md.</b>   |                            | <b>25A. DATE REC'D BY HEALTH DEPT.</b><br><b>OCT 27 1969</b>   |   |   |
| <b>25B. NAME OF REGISTRAR</b><br><b>Robert E. [Signature]</b>   |                            | <b>25C. FUNERAL DIRECTOR</b><br><b>[Signature]</b>   |   |   |
| <b>25D. ADDRESS</b><br><b>[Signature]</b>   |                            | <b>25E. ADDRESS</b><br><b>[Signature]</b>  |   |   |





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|------------------|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT  |                  | REG. NO. <b>69 10524</b>  |  |
| BIRTH NO. <b>5-536 69 10524</b>   |                  | CERTIFICATE OF DEATH  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>James Paul Sanders</b>  |                  | 2. DATE AND HOUR OF DEATH<br><b>10/23/69 12<sup>00</sup> PM.</b>  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD</b> B. COUNTY <b>1504</b>                           |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>University of Maryland Hospital</b>   |                  | C. CITY OR TOWN <b>BA 170</b> D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |  |
| E. STREET AND NUMBER<br><b>1612 Clifton Avenue</b>  |                  |   |  |
| 5. SEX <b>M</b>   | 6. RACE <b>N</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>8-25-38</b>                                 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Chauffeur</b>   |                  | 9. AGE (In years last birthday)<br><b>31</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>North Carolina</b> |
| 13. FATHER'S NAME<br><b>James Davis</b>   |                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                  | 16. SOCIAL SECURITY NO.<br><b>214-38-2343</b>   | 17. INFORMANT<br><b>Mattie Hooks</b>                               |
|   |                  | ADDRESS<br><b>895 Reinhardt</b>   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Septic Shock</b>   |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b>  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Acute Hemorrhagic Pancreatitis</b>   |                  | <b>1 week</b>   |  |
|   |                  | <b>3 days</b>   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                  |   |  |
| 19A. DATE OF OPERATION<br><b>10/23</b>  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20A. AUTOPSY? (Yes or No)   |                  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |
| 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |                  |   |  |
| 21D. TIME OF INJURY (APPROX.)<br>I (Month) (Day) I (Year) I (Hour)  |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  |
| 21F. HOW DID INJURY OCCUR?  |                  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10/23</b> 19 <b>69</b> to <b>10/23</b> 19 <b>69</b> that (I) ( <del>we</del> ) last saw the deceased alive on <b>10/23</b> 19 <b>69</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) (did not) view the body after death. |                  |   |  |
| 23A. SIGNATURE<br><b>Richard A. Baum MD</b>   |                  | 23B. DATE SIGNED<br><b>10/24/69</b>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Richard A. Baum</b>  |                  | 23D. ADDRESS<br><b>University of Maryland Hospital</b>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                  | 24B. DATE<br><b>10-28-69</b>  |  |
| 24C. NAME OF CEMETERY OR CREMATORY<br><b>MT. AUBURN</b>   |                  | 24D. LOCATION<br><b>BALTO., Md.</b>   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 27 1969</b>   |                  | 25B. NAME OF REGISTRAR<br><b>Charles E. Rice</b>  |  |
| 25C. FUNERAL DIRECTOR<br><b>CHARLES A. RICE</b>   |                  | ADDRESS<br><b>661 W. BARRE ST.</b>  |  |

1910

1911

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1914

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1918

1919

1920

1921

1922

1923

69 10525 CERTIFICATE OF DEATH

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |   |   |
|---|--|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Mildred Thomas (Doris)</b>  |  | 2. DATE AND HOUR OF DEATH<br><b>10/23/69 1:45 P.M.</b>  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Baltimore City Hospitals<br/>4940 Eastern Ave.<br/>Baltimore, Md. 21224</b>   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Maryland</b><br>C. CITY OR TOWN <b>Baltimore</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>2665 Lauretta Ave. 21223 007</b> |   |
| 5. SEX <b>Female</b>  | 6. RACE <b>Negro</b>                           | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <b>3-25-15</b>                                   |
| 9. AGE (In years last birthday) <b>54</b>   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |   |
| 11. BIRTHPLACE (State or foreign country) <b>N.C.</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |   |
| 13. FATHER'S NAME <b>John Brown</b>   |  | 14. MOTHER'S MAIDEN NAME <b>Ethel</b>   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO. <b>217-24-6795</b>  |   |
| 17. INFORMANT <b>BCH Records: Baltimore, Md. 21224</b>  |  | ADDRESS <b>4940 Eastern Ave.</b>  |   |
| 18. I <b>4109</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>MI</b><br><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) <b>CHF</b>  |   |
| 19. DATE OF OPERATION <b>2</b>  |  | 20. AUTOPSY? (Yes or No) <b>YES</b>   |   |
| 21. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  | 22. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>  |   |
| 21A. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  | 21D. HOW DID INJURY OCCUR?  |   |
| 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10/1/69</b> 19 to <b>10/23/69</b> 19, that (I) (we) last saw the deceased alive on <b>10/23/69</b> 19 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                      |  |   |   |
| 23A. SIGNATURE <b>Charles R. Wands M.D.</b>   |  | 23B. DATE SIGNED <b>10/23/69</b>  |   |
| 23C. PHYSICIAN'S NAME (Type) <b>Jack R. Wands M.D.</b>  |  | 23D. ADDRESS <b>Baltimore City Hospitals<br/>4940 Eastern Ave. Baltimore, Md. 21224</b>   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>  | 24B. DATE <b>10/28/69</b>                      | 24C. NAME OF CEMETERY OR CREMATORY <b>Mt Auburn</b>   | 24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b> |
| 25A. DATE REC'D BY HEALTH DEPT. <b>OCT 27 1969</b>  | 25B. NAME OF REGISTRAR <b>Robert E. Taylor</b> | 25C. FUNERAL DIRECTOR <b>Charles R. Wands</b>   | 25D. ADDRESS <b>661 W. B. Wands</b>                               |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                     |  |   | REG. NO.   | 69 10526   |
|---|---------------------|--|---|--|--|
| <b>BIRTH NO.</b><br><b>1. NAME OF DECEASED</b><br>(Type or Print)   |                     | <b>2. DATE AND HOUR OF DEATH</b><br>Oct. 25, 1969 10 17 M.   |   |  |  |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><br>102 W. 39th Street Apt. 1A  |                     | <b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)<br>A. STATE B. COUNTY<br>Maryland 1201<br><b>C. CITY OR TOWN</b> Baltimore<br><b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br><b>E. STREET AND NUMBER</b> 102 W. 39th Street Apt. 1A |   |  |  |
| <b>5. SEX</b><br>F  | <b>6. RACE</b><br>W | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |   | <b>8. DATE OF BIRTH</b><br>1-9-1893  | <b>9. AGE</b> (In years last birthday) 76<br>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br>Homemaker   |                     | <b>10B. KIND OF BUSINESS OR INDUSTRY</b><br>Own Home   |   | <b>11. BIRTHPLACE</b> (State or foreign country) Buffalo, New York<br><b>12. CITIZEN OF WHAT COUNTRY?</b> U.S.A. |  |
| <b>13. FATHER'S NAME</b><br>William Nordhoff  |                     |  | <b>14. MOTHER'S MAIDEN NAME</b><br>Mary Redmond |  |  |
| <b>15. Was Deceased Ever in U. S. Armed Forces?</b><br>(Yes, no or unknown) (If yes, give war or dates of service)<br>No  |                     | <b>16. SOCIAL SECURITY NO.</b><br>216-46-9593  |   | <b>17. INFORMANT</b> Mr. C. Albert Haugh<br><b>ADDRESS</b> Same  |  |
| <b>18. CAUSE OF DEATH</b>   |                     |  |   |  |  |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br/>                     (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br/><br/> <b>ANTECEDENT CAUSES</b><br/>                     DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                 </div> <div style="width: 45%;"> <b>(A) IMMEDIATE CAUSE</b> <i>Cerebral thrombosis</i><br/>                     DUE TO, OR AS A CONSEQUENCE OF:<br/><br/> <b>(B) <i>Cerebral arteriosclerosis</i></b><br/>                     DUE TO, OR AS A CONSEQUENCE OF:<br/><br/> <b>(C)</b> </div> <div style="width: 10%; text-align: center;"> <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b><br/> <i>2 days</i><br/><br/> <i>2 + yrs</i> </div> </div> |                     |  |   |  |  |
| <b>II</b>   |                     |  |   |  |  |
| <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>   |                     |  |   |  |  |
| <b>19A. DATE OF OPERATION</b><br>0  |                     | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>  |   | <b>20A. AUTOPSY?</b> (Yes or No) No  |  |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>   |                     | <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)                                  |  |
| <b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)  |                     | <b>21E. INJURY OCCURRED</b><br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |   | <b>21F. HOW DID INJURY OCCUR?</b>  |  |
| <b>22. I certify that (I) (this hospital) attended the deceased from 3/2 1967 to 10/25 1969, that (I) (we) last saw the deceased alive on 10/27/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>   |                     |  |   |  |  |
| <b>23A. SIGNATURE</b><br><b>23C. PHYSICIAN'S NAME</b> (Type) Dr. William F. Renner  |                     |  |   | <b>23B. DATE SIGNED</b> 10/27/69<br><b>23D. ADDRESS</b> 3222 St. Paul Street                                     |  |
| <b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) Burial  |                     | <b>24B. DATE</b> 10-28-1969  |   | <b>24C. NAME OF CEMETERY or CREMATORY</b> Druid Ridge Cemetery   |  |
| <b>24D. LOCATION</b> (City, town, or county) Pikesville, / Balto. Co., Md.  |                     | <b>25A. DATE REC'D BY HEALTH DEPT.</b> OCT 27 1969   |   |  |  |
| <b>25B. NAME OF REGISTRAR</b> Robert E. Fisher, M.D.  |                     | <b>25C. FUNERAL DIRECTOR</b> H. W. Jenkins & Sons Co. 4905 York Road Balto., Md.   |   |  |  |

*Chrysomelids*

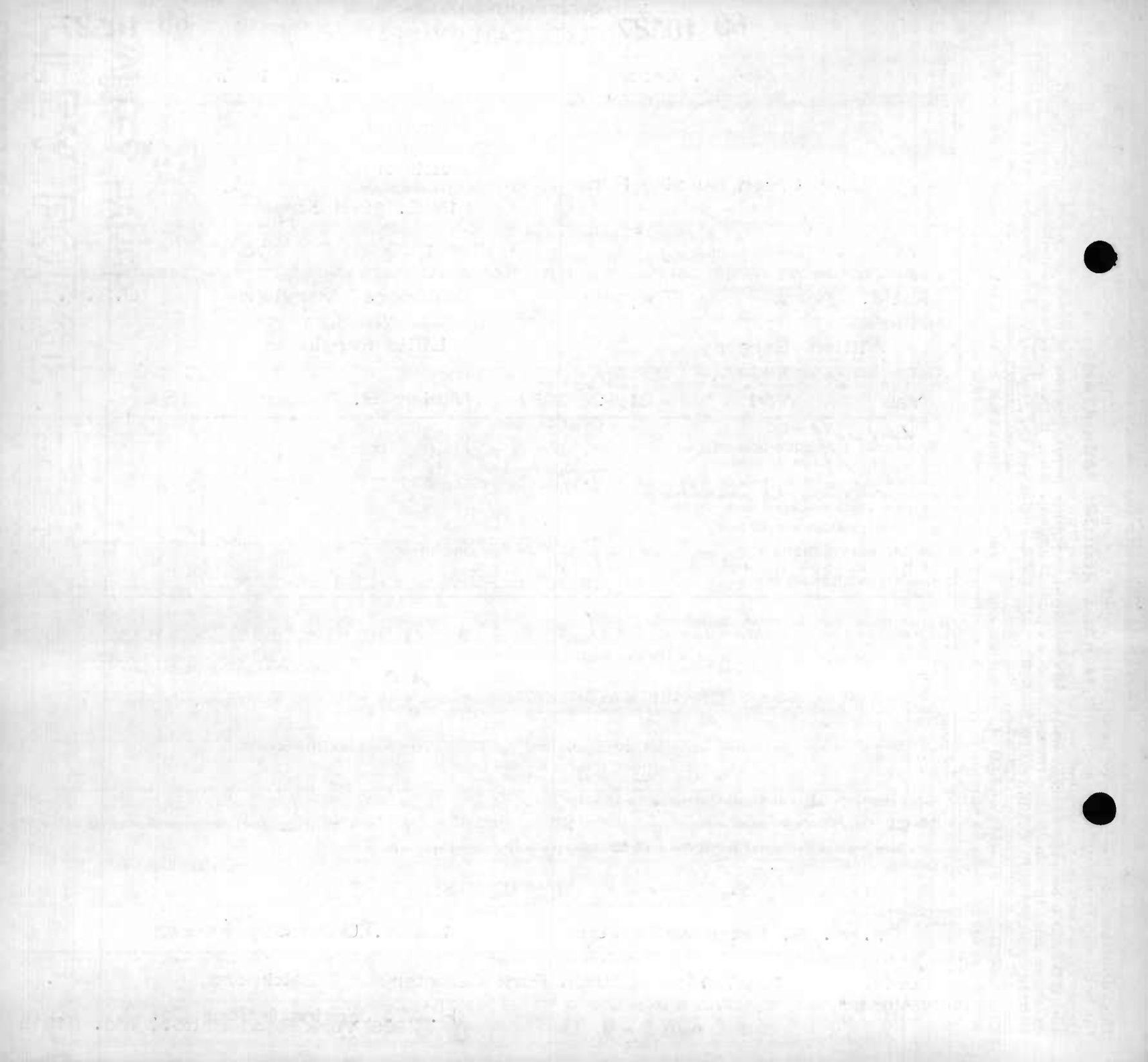
25/04/50

5/5/21

Wm. P. Burrows

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



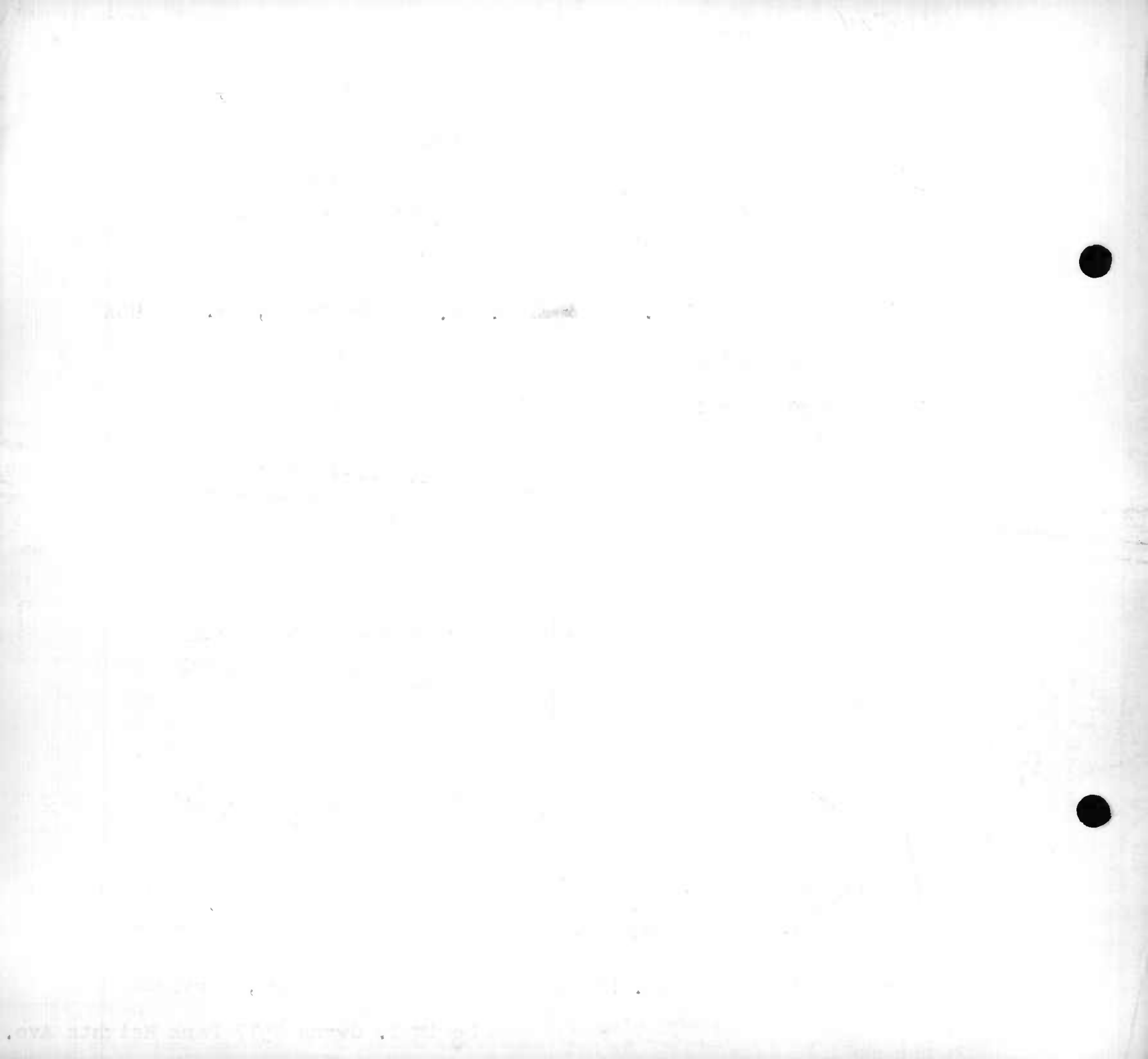




FUNERAL DIRECTOR: IMPORTANT

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|  |                     |   |                                    |   |   |   |  |
|--|---------------------|---|------------------------------------|---|---|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT   |                     | 69 10528  |                                    | CERTIFICATE OF DEATH  |   | 69 10528  |  |
| BIRTH NO. <span style="font-size: 2em;">C-514</span>   |                     | NAME OF DECEASED<br>(Type or Print) <b>CHAMBLISS ROBERT</b>   |                                    | DATE AND HOUR OF DEATH<br><b>10/24/69</b>                                   |   | REG. NO. <span style="font-size: 1.5em;">V-55A</span>   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                     | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD.</b><br>B. COUNTY <b>2841</b>                       |                                    | C. CITY OR TOWN<br><b>Baltimore</b>   |   | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Senai Hosp. of Baltimore</b><br><b>Belvedere Ave. at Greenpring</b>   |                     | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |                                    | E. STREET AND NUMBER<br><b>3707 N Rogers Ave #15</b>                        |   |   |  |
| 5. SEX<br><b>M</b>   | 6. RACE<br><b>N</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6/27/96</b> | 9. AGE (In years last birthday)<br><b>73</b>                                | If Under 1 Yr. Months Days<br>If Under 24 Hrs. Hours Min. |   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Dripman</b>  |                     | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Balto. Gas &amp; Elec. Co.</b>  |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>Stony Creek, Va.</b>        |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Robert Chambliss</b>   |                     | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |                                    |   |   |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes World War I</b>   |                     | 16. SOCIAL SECURITY NO.<br><b>212 05 3243</b>   |                                    | 17. INFORMANT<br><b>A Patients' chart</b>                                   |   | ADDRESS   |  |
| 18. <b>203X1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b><br>(A) IMMEDIATE CAUSE <b>Carcinoma of Stomach</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <b>Multiple Myeloma</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>Coronary Artery Disease</b> |                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                                    |   |   |   |  |
| 19A. DATE OF OPERATION<br><b>0</b>   |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                    | 20A. AUTOPSY? (Yes or No)<br><b>No</b>                                      |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                    | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location) |   |   |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                                    | 21F. HOW DID INJURY OCCUR?  |   |   |  |
| 22. I certify that <b>it</b> (this hospital) attended the deceased from <b>10/6</b> <b>1969</b> to <b>10/24</b> <b>1969</b> that <b>it</b> (we) last saw the deceased alive on <b>10/24</b> <b>1969</b> and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>it</b> (We) (did) (did not) view the body after death.  |                     |   |                                    |   |   |   |  |
| 23A. SIGNATURE<br><b>Joseph F. Calimlim MD</b>   |                     | 23B. DATE SIGNED<br><b>10/24/69</b>   |                                    | 23C. PHYSICIAN'S NAME (Type)<br><b>JOSEPH F. CALIMLIM MD</b>                |   | 23D. ADDRESS<br><b>Senai Hospital of Balto.</b>   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                     | 24B. DATE<br><b>10/28/69</b>  |                                    | 24C. NAME OF CEMETERY or CREMATORY<br><b>St. Lukes Cemetery</b>             |   | 24D. LOCATION (City, town, or county) (State)<br><b>Hereford, Maryland</b>                    |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 27 1969</b>  |                     | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor</b>   |                                    | 25C. FUNERAL DIRECTOR<br><b>Lewis T. Gwynn</b>                              |   | ADDRESS<br><b>4517 Park Heights Ave.</b>  |  |



# FUNERAL DIRECTOR: IMPORTANT

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| BALTIMORE CITY HEALTH DEPARTMENT   |                                |  |  | REG. NO. <span style="float: right;">69 10529</span>                            |   |
|--|--------------------------------|--|--|---|---|
| <div style="display: flex; justify-content: space-between;"> <span><b>S-326</b></span> <span><b>69 10529</b></span> </div> <div style="text-align: center; font-weight: bold; font-size: 1.2em;">CERTIFICATE OF DEATH</div>  |                                |  |  |   |   |
| <b>BIRTH NO.</b><br><b>1. NAME OF DECEASED</b><br>(Type or Print) <span style="float: right;"><i>Hester E. Scheidegger</i></span>  |                                |  | <b>2. DATE AND HOUR OF DEATH</b><br><div style="display: flex; justify-content: space-between;"> <span><i>Oct. 22, 1969</i></span> <span><i>8:50 P.</i></span> </div>  |   |   |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><div style="font-size: 1.5em; margin-top: 10px;"><i>00 1621 Enson Street</i></div>   |                                |  | <b>4. USUAL RESIDENCE</b> (Where deceased lived, If institution: residence before admission)<br>A. STATE <span style="float: right;"><i>Maryland</i></span><br>B. COUNTY <span style="float: right;"><i>909</i></span><br>C. CITY OR TOWN <span style="float: right;"><i>Baltimore</i></span><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <span style="float: right;"><i>1621 Enson Street -21202</i></span> |   |   |
| <b>5. SEX</b><br><i>Female</i>   | <b>6. RACE</b><br><i>White</i> | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | <b>8. DATE OF BIRTH</b><br><i>June 4, 1906</i>   | <b>9. AGE</b> (In years last birthday)<br><i>63</i>                             | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.   |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><i>Factory Work</i>  |                                | <b>10B. KIND OF BUSINESS OR INDUSTRY</b><br><i>Voneiff &amp; Drayer</i>  |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><i>Balto. Co. Md.</i>       |   |
| <b>12. CITIZEN OF WHAT COUNTRY?</b><br><i>U.S.A.</i>   |                                |  | <b>13. FATHER'S NAME</b><br><i>Charles Keller</i>  |   |   |
| <b>14. MOTHER'S MAIDEN NAME</b><br><i>Lillian McMan</i>  |                                |  | <b>15. Was Deceased Ever in U. S. Armed Forces?</b><br>(Yes, no or unknown) (If yes, give war or dates of service)<br><i>No</i>  |   |   |
| <b>16. SOCIAL SECURITY NO.</b><br><i>214-14-7509</i>   |                                |  | <b>17. INFORMANT</b><br><i>William D. Scheidegger - 1621 Enson St.</i>   |   |   |
| <b>18. CAUSE OF DEATH</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>Sudden</i>  |   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><i>Cirrhosis of Liver</i>  |                                |  |  |   |   |
| <b>19A. DATE OF OPERATION</b><br><i>0</i>  |                                | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>  |  | <b>20A. AUTOPSY?</b> (Yes or No)  |   |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>  |                                | <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) |   |
| <b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)   |                                | <b>21E. INJURY OCCURRED</b><br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | <b>21F. HOW DID INJURY OCCUR?</b>   |   |
| <b>22. I certify that (I) (this hospital) attended the deceased from</b> <i>2/26 1969</i> <b>to</b> <i>10/22 1969</i> <b>and that (I) (we) lost</b> <i>10/22 1969</i> <b>and that (my) (our) opinion death occurred on the date</b> <i>10/22 1969</i> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>          |                                |  |  |   |   |
| <b>23A. SIGNATURE</b><br><i>Joseph S. Blum</i>   |                                |  | <b>23B. DATE SIGNED</b><br><i>10/23/69</i>   |   | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |
| <b>23C. PHYSICIAN'S NAME</b> (Type)<br><i>JOSEPH S. BLUM MD</i>  |                                |  | <b>23D. ADDRESS</b><br><i>1115 N. CALVERT ST</i>   |   |   |
| <b>24A. BURIAL CREMATION, REMOVAL</b> (Specify)<br><i>Burial</i>   |                                | <b>24B. DATE</b><br><i>10-25-69</i>  |  | <b>24C. NAME OF CEMETERY or CREMATORY</b><br><i>Baltimore Cemetery</i>          |   |
| <b>24D. LOCATION</b> (City, town, or county)<br><i>Baltimore, Md.</i>  |                                | <b>24E. STATE</b> (State)<br><i>Md.</i>  |  |   |   |
| <b>25A. DATE REC'D BY HEALTH DEPT.</b><br><i>OCT 27 1969</i>   |                                | <b>25B. NAME OF REGISTRAR</b><br><i>John G. Miller</i>   |  | <b>25C. FUNERAL DIRECTOR</b><br><i>John G. Miller Inc-6415 Belair Rd.-21206</i> |   |
| <b>25D. ADDRESS</b><br>  |                                |  |  |   |   |



| BIRTH NO.   |  | 69 10530 |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  | REG. NO. 69 10530   |  |
|---|--|----------|--|---|--|---|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>Clarence Paul Arnold</b>   |  |          |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>                  |  | Month Day Year  |  | Hour  |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>38 University Hospital</b>   |  |          |  | 3. DATE PRONOUNCED DEAD<br><b>October 23, 1969</b>  |  | Month Day Year  |  | Hour <b>1:13 P.M.</b>   |  |
| 6. SEX<br><b>Male</b>   |  |          |  | 7. RACE<br><b>White</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Anne Arundel</b> |  |
| 9. DATE OF BIRTH<br><b>11/21/18</b>   |  |          |  | 10. AGE (In years last birthday)<br><b>50</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Tennessee</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Carpenter</b>  |  |          |  | 14B. KIND OF BUSINESS OR INDUSTRY<br><b>U. S. Gov.</b>  |  | 15. MOTHER'S MAIDEN NAME<br><b>unknown</b>  |  | 13. FATHER'S NAME<br><b>Clarence Arnold</b>   |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes 1942 - 1944</b>   |  |          |  | 17. SOCIAL SECURITY NO.   |  | 18. INFORMANT<br><b>Carl W. Arnold</b>  |  | ADDRESS <b>Md. 28 Williams Dr. Brandywine</b>   |  |
| 19. <b>E 955 X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Bronchopneumonia and peritonitis complicating Gunshot wound of chest</b>   |  |          |  | CAUSE OF DEATH<br><b>complicating Gunshot wound of chest</b>  |  | DUE TO, OR AS A CONSEQUENCE OF:   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 20A. DATE OF OPERATION  |  |          |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 21. AUTOPSY? (Yes or No)  |  |   |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |          |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>house</b>          |  | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br><b>1630 Dryden Way 5200</b>   |  |   |  |
| 22D. TIME OF INJURY (APPROX.)<br><b>10 8 69 7P.m.</b>   |  |          |  | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> |  | 22F. HOW DID INJURY OCCUR?<br><b>Subject shot self.</b>   |  |   |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |          |  | ACTUAL SIGNATURE<br><b>Werner U. Spitz, M.D.</b>  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | DATE SIGNED   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |          |  | 24B. DATE<br><b>10-27-69</b>  |  | 24C. NAME of CEMETERY or CREMATORY<br><b>Ft. Lincoln Cemetery</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>Bladensburg, Md.</b>  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 27 1969</b>   |  |          |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>   |  | 25C. FUNERAL DIRECTOR<br><b>Wilhelm Funeral Home</b>  |  | ADDRESS<br><b>4308 Suitland Rd. Suitland, Md.</b>   |  |

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| K-520 69 10531   |                           |   |                                     | BALTIMORE CITY HEALTH DEPARTMENT   |   | REG. NO. 69 10531   |   |
|--|---------------------------|---|-------------------------------------|--|---|---|---|
| BIRTH NO.  |                           |   |                                     | CERTIFICATE OF DEATH   |   |   |   |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Monnie B. King</u>   |                           |   |                                     | 2. DATE AND HOUR OF DEATH<br><u>10-23-69</u> <u>10:15 P.</u> M.  |   |   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                           |   |                                     | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>md.</u> B. COUNTY <u>1608</u> |   |   |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>46 Lutheran Hospital</u>  |                           |   |                                     | C. CITY OR TOWN<br><u>Baltimore</u>  |   | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |                           |   |                                     | E. STREET AND NUMBER<br><u>733 Grantley St.</u>  |   |   |   |
| 5. SEX<br><u>Female</u>  | 6. RACE<br><u>Colored</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>9-5-1906</u> | 9. AGE (In years lost birthday)<br><u>63</u>   | 11. Under 1 Yr. Months: Days: Hours: Min. |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Domestic</u>   |                           | 10B. KIND OF BUSINESS OR INDUSTRY   |                                     | 11. BIRTHPLACE (State or foreign country)<br><u>Roxboro, N.C.</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |
| 13. FATHER'S NAME<br><u>UNKNOWN</u>  |                           |   |                                     | 14. MOTHER'S MAIDEN NAME<br><u>UNKNOWN</u>   |   |   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>NO</u>  |                           | 16. SOCIAL SECURITY NO.<br><u>242-58-1725</u>   |                                     | 17. INFORMANT<br><u>Ralph B. Bland</u> ADDRESS <u>733 Grantley St.</u>   |   |   |   |
| 18. <u>394.7</u> CAUSE OF DEATH  |                           |   |                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |   |   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><u>MITRAL INFARCTION</u>  |                           |   |                                     | <u>Sudden</u>  |   |   |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.   |                           |   |                                     | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><u>Hypertension Cerebral Vascular Disease</u>                               |   |   |   |
|  |                           |   |                                     | (B) DUE TO, OR AS A CONSEQUENCE OF:<br><u>None</u>   |   |   |   |
|  |                           |   |                                     | (C) _____  |   |   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                           |   |                                     |  |   |   |   |
| 19A. DATE OF OPERATION<br><u>0</u>   |                           | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                     | 20A. AUTOPSY? (Yes or No)<br><u>NO</u>   |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |                           | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                     | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)  |   |   |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  |                           | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                                     | 21F. HOW DID INJURY OCCUR?   |   |   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <u>8-1-69</u> 19 to <u>10-23-1969</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>10-20-69</u> 19 and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(We)</del> <del>(did)</del> (did not) view the body after death. |                           |   |                                     |  |   |   |   |
| 23A. SIGNATURE<br><u>Maurice L. Adams M.D.</u>   |                           |   |                                     | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>    |   | 23B. DATE SIGNED<br><u>10-24-69</u>   |   |
| 23C. PHYSICIAN'S NAME (Type)<br><u>MAURICE L. ADAMS</u>  |                           |   |                                     | 23D. ADDRESS<br><u>238 N. Carey St. - Baltimore</u>  |   |   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                           | 24B. DATE<br><u>10-27-69</u>  |                                     | 24C. NAME OF CEMETERY or CREMATORY<br><u>Carver Memorial Pk.</u>   |   | 24D. LOCATION (City, town, or county) (State)<br><u>Laurel, Md.</u>                           |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>OCT 27 1969</u>  |                           | 25B. NAME OF REGISTRAR<br><u>Robert E. Taylor</u>   |                                     | 25C. FUNERAL DIRECTOR<br><u>Ralph J. Collick</u>   |   | ADDRESS<br><u>2431 E. Oliver St.</u>  |   |



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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                         |   |  |
|--|-------------------------|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT   |                         | REG. NO. <b>69 10532</b>  |  |
| B-300 69 10532   |                         | CERTIFICATE OF DEATH  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>BUTTE, LYDIA F.</b>  |                         | 2. DATE AND HOUR OF DEATH<br><b>10-23-69 9.00 AM</b>  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>BALTO</b> B. COUNTY <b>5300</b>                        |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>LUTHERAN HOSPITAL OF MARYLAND</b><br><b>730 ASHBURTON ST. BALTIMORE, MD. 21216</b>   |                         | C. CITY OR TOWN<br><b>BALTIMORE</b>   | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| E. STREET AND NUMBER<br><b>6711 CAMPFIELD ROAD</b>   |                         |   |  |
| 5. SEX<br><b>FEMALE</b>  | 6. RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>APR 10, 1884</b>  |
| 9. AGE (In years last birthday)<br><b>85</b>   |                         | If Under 1 Yr. Months: Days: Hours: Min.  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>CATERING MNG.</b>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>BALTO CO SCHOOL</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>BALTO CO</b>   |                         | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME<br><b>JOHN W. FITZELL</b>  |                         | 14. MOTHER'S MAIDEN NAME<br><b>KRAUK</b>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |                         | 16. SOCIAL SECURITY NO.<br><b>36-1008</b>   |  |
| 17. INFORMANT<br><b>RECORDS</b>  |                         | ADDRESS<br><b>CAMPFIELD RD AUGSBURG HOME</b>  |  |
| 18. <b>412.3 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>ARTERIO-SCLEROTIC HEART DISEASE</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                         | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>HEART FAILURE</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>FRACTURE OF LEFT HIP</b><br>(C)    |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |                         |   |  |
| 19A. DATE OF OPERATION<br><b>10-6-69</b>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Fracture Left Femur</b>  |  |
| 20A. AUTOPSY? (Yes or No)<br><b>No</b>   |                         | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                         |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  |
| 21F. HOW DID INJURY OCCUR?   |                         |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>9-30-1969</b> to <b>10-23-1969</b> , that (I) (we) last saw the deceased alive on <b>10-23-1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                         |   |  |
| 23A. SIGNATURE<br><b>M.R. BS.</b>  |                         | 23B. DATE SIGNED<br><b>10-23-69</b>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>PREM LAL</b>  |                         | 23D. ADDRESS<br><b>LUTHERAN HOSPITAL OF MARYLAND</b><br><b>730 ASHBURTON ST. BALTO. MD. 21216</b>   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 24B. DATE<br><b>OCT 25 69</b>   |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Mountland</b>   |                         | 24D. LOCATION (City, town, or county) (State)<br><b>Balto Co</b>  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 27 1969</b>  |                         | 25B. NAME OF REGISTRAR<br><b>Robert J. [unclear]</b>  |  |
| 25C. FUNERAL DIRECTOR<br><b>W. J. [unclear]</b>  |                         | ADDRESS<br><b>Harford Rd</b>  |  |

Sept 24 1891

Dear Sir,

I have the honor to acknowledge the receipt of your letter of the 21st inst. in relation to the matter of the

Yours very truly,

Wm. H. Smith

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT

## 69 10533 CERTIFICATE OF DEATH

REG. NO. 69 10533

|  |                     |   |  |   |   |
|--|---------------------|---|--|---|---|
| BIRTH NO.  |                     | 1. NAME OF DECEASED<br>(Type or Print) <b>FRANK ROSE</b>  |  | 2. DATE AND HOUR OF DEATH<br><b>10/26/69 2:15 PM.</b>   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                     |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD</b> B. COUNTY <b>2706</b> |   |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Union Memorial Hospital</b>  |                     |   |  | C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |   |
| E. STREET AND NUMBER<br><b>5506 Hampnett Ave</b>   |                     |   |  |   |   |
| 5. SEX<br><b>M</b>   | 6. RACE<br><b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>7/16/87</b>   | 9. AGE (In years lost birthday)<br><b>82</b>  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>LABORER BALTO CITY</b>   |                     |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>RETIRED</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>IRAN</b>  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                     |   | 13. FATHER'S NAME<br><b>RAPHONSE RITAROSI</b>  |   |   |
| 14. MOTHER'S MAIDEN NAME<br><b>? UNKNOWN</b>   |                     |   | 15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service)<br><b>NO</b>   |   |   |
| 16. SOCIAL SECURITY NO.<br><b>214-40-6985A</b>   |                     |   | 17. INFORMANT<br><b>MICHAEL J. ROSE</b> ADDRESS <b>5506 HAMPNETT AVE #14</b>   |   |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)<br><b>205.0 I</b>   |                     |   | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>acute myocardial infarction</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b> |   |   |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>ASCVD</b>   |                     |   |  |   |   |
| 19A. DATE OF OPERATION<br><b>0</b>   |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10/18/1969</b> to <b>10/26/1969</b> , that (I) (we) last saw the deceased alive on <b>10/26/1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                     |   |  |   |   |
| 23A. SIGNATURE<br><b>Donald J. Fisher MD</b>   |                     |   |  | 23B. DATE SIGNED<br><b>10/28/69</b>   |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>RONALD V. GRIFFIN MD</b>  |                     |   |  | 23D. ADDRESS<br><b>Union Memorial Hosp Maryland</b>   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                     | 24B. DATE<br><b>OCT. 29 1969</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cemetery Baltimore Maryland</b>  |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore Maryland</b>   |                     | 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 28 1969</b>   |  |   |   |
| 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor</b>  |                     | 25C. FUNERAL DIRECTOR<br><b>Doreen Beginc 7110 BELAIR RD</b>  |  |   |   |

62.1057

Frank Cox

Md

Union Memorial Hospital Baltimore

2202 Hanover Ave

7/16/57

Idol

James K. Jones

cut off

Micro

no

10/15/57

Frank J. Jones

James K. Jones

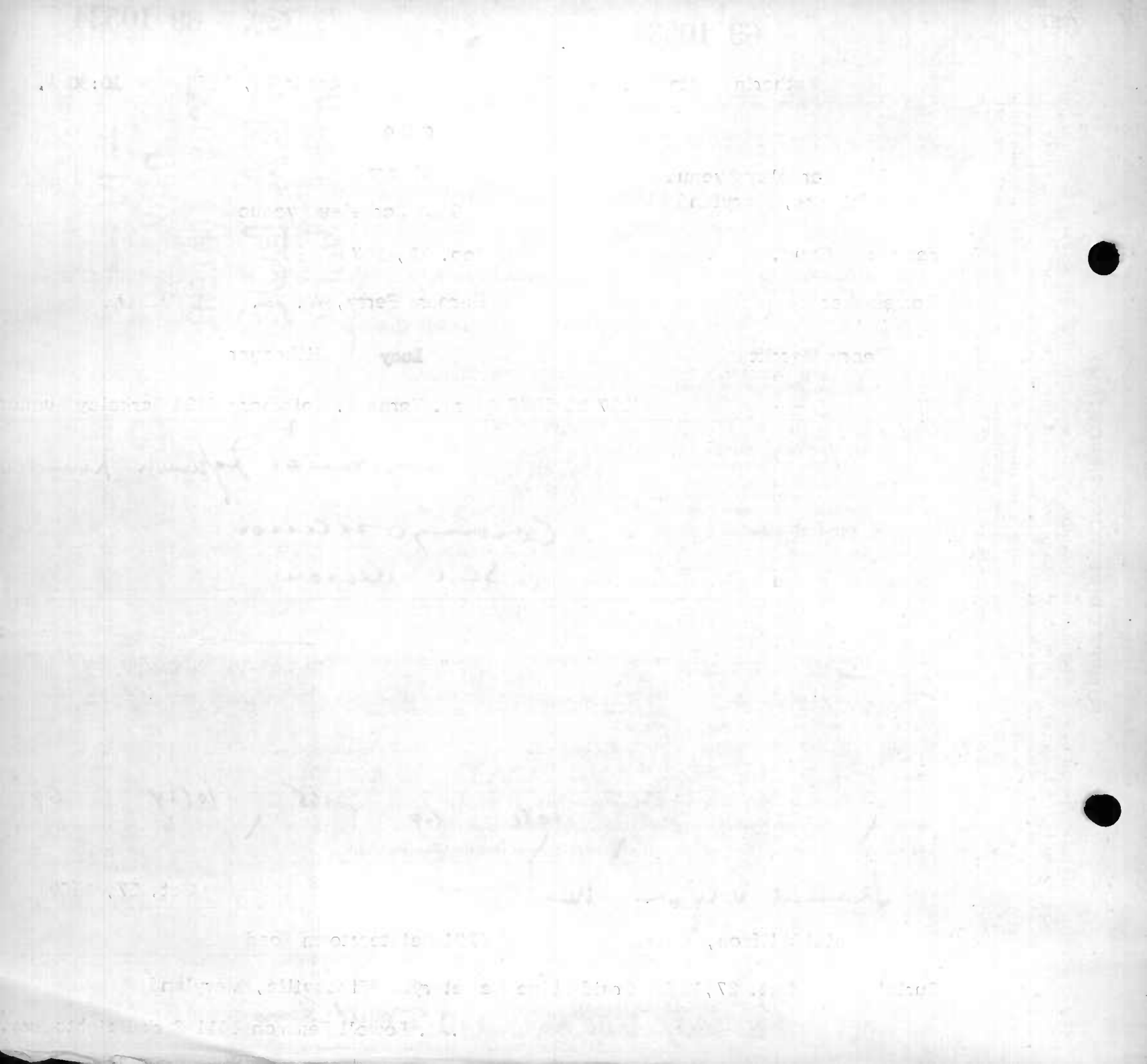
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 69 10534 CERTIFICATE OF DEATH

REG. NO. 69 10534

|   |                            |   |  |  |   |
|---|----------------------------|---|--|--|---|
| BIRTH NO.   |                            | 1. NAME OF DECEASED<br>(Type or Print) Katherine Estelle GURISCH  |  | 2. DATE AND HOUR OF DEATH<br>October 24, 1969 10:30 A. M.                |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                            |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland B. COUNTY 2740  |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>6024 Berkeley Avenue<br>00 Baltimore, Maryland 21209  |                            |   | C. CITY OR TOWN<br>Baltimore   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|   |                            |   | E. STREET AND NUMBER<br>6024 Berkeley Avenue   |  |   |
| 5. SEX<br>Female  | 6. RACE<br>Cauc.           | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>Sep. 12, 1879  | 9. AGE (In years last birthday)<br>90                                    | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Homemaker  |                            | 10B. KIND OF BUSINESS OR INDUSTRY<br>- - -  |  | 11. BIRTHPLACE (State or foreign country)<br>Harpers Ferry, W. Va.       |   |
| 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |                            |   |  |  |   |
| 13. FATHER'S NAME<br>Henry Merritt  |                            |   | 14. MOTHER'S MAIDEN NAME<br>Lucy Billmeyer   |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO - - -  |                            | 16. SOCIAL SECURITY NO.<br>217 22 5886  |  | 17. INFORMANT<br>Mrs. Verna E. Spitzberg 6024 Berkeley Avenue            |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>410.9 I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |                            |   | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction Immediate<br>(B) Coronary occlusion<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) A SCV disease |  |   |
| MEDICAL CERTIFICATION<br>19A. DATE OF OPERATION<br>0  |                            |   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |                            | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)  |                            | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from 1965 to 10/24 1969, that (I) (we) last saw the deceased alive on 10/1 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                            |   |  |  |   |
| 23A. SIGNATURE<br>Daniel Wilfson M.D.   |                            |   |  | 23B. DATE SIGNED<br>Oct. 27, 1969  |   |
| 23C. PHYSICIAN'S NAME (Type)<br>Daniel Wilfson, M.D.  |                            |   |  | 23D. ADDRESS<br>5721 Reisterstown Road                                   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  | 24B. DATE<br>Oct. 27, 1969 | 24C. NAME of CEMETERY or CREMATORY<br>Druid Ridge Cemetery  |  | 24D. LOCATION (City, town, or county) (State)<br>Pikesville, Maryland    |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br>OCT 28 1969  |                            | 25B. NAME OF REGISTRAR<br>Robert E. Sabin, M.D.   |  | 25C. FUNERAL DIRECTOR<br>J. E. Lowell Lemmon 4611 Park Heights Ave.      |   |





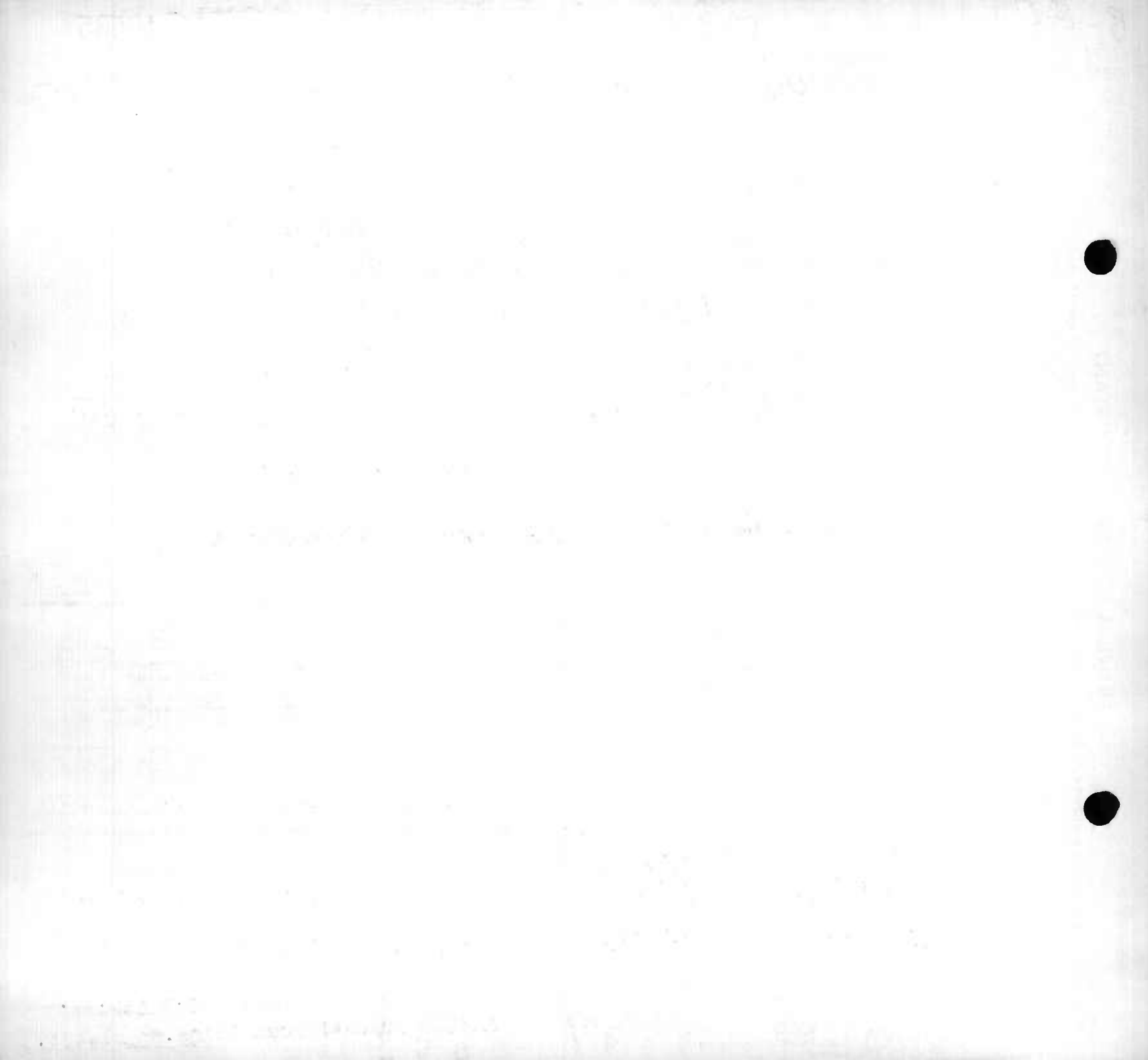
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 10535 CERTIFICATE OF DEATH

REG. NO. 69 10535

|   |                         |  |                                    |  |  |
|---|-------------------------|--|------------------------------------|--|--|
| BIRTH NO.   |                         | 1. NAME OF DECEASED<br>(Type or Print) <b>EDMUND J. BROPHY</b>   |                                    | 2. DATE AND HOUR OF DEATH<br><b>10-25-69 3:45 A.M.</b>   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>1902</b>                                  |                                    | C. CITY OR TOWN <b>Baltimore 23</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>South Baltimore General Hosp.</b>  |                         | E. STREET AND NUMBER<br><b>315 S Gilmore St</b>  |                                    |  |  |
| 5. SEX<br><b>Male</b>   | 6. RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>              | 8. DATE OF BIRTH<br><b>6-29-98</b> | 9. AGE (In years last birthday)<br><b>71</b>   | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>   |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Post Office</b>   |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |                         | 13. FATHER'S NAME<br><b>James B (dec)</b>  |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Rose Connolly (dec)</b>   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no none</b>  |                         | 16. SOCIAL SECURITY NO.<br><b>216-16-3529</b>  |                                    | 17. INFORMANT<br><b>John L. Brophy - 315 S. Gilmore St.</b>  |  |
| 18. I <b>I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.      |                         | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <b>CARCINOMATOUS</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <b>CANCER OF BRONCHUS</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) |                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                         |  |                                    |  |  |
| 19A. DATE OF OPERATION<br><b>10-25-69</b>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                    | 20A. AUTOPSY? (Yes or No)  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Initially medical examiner)  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                                    | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10-2</b> 19 <b>69</b> to <b>10-25</b> 19 <b>69</b> that (I) (we) last saw the deceased alive on <b>10-25</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. |                         |  |                                    |  |  |
| 23A. SIGNATURE<br><b>Mariano A Tolentino</b>  |                         | 23B. DATE SIGNED<br><b>10-25-69</b>  |                                    | 23C. PHYSICIAN'S NAME (Type)<br><b>MARIANO A TOLENTINO</b>   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 24B. DATE<br><b>10/28/69</b>   |                                    | 24C. NAME of CEMETERY or CREMATORY<br><b>New Cathedral Cemetery</b>  |  |
| 24D. LOCATION (City, town, or county)<br><b>Old Frederick Rd. Balto. Md.</b>  |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 28 1969</b>  |                                    | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>  |  |
| 25C. FUNERAL DIRECTOR<br><b>KRAUSE FUNERAL HOME</b>   |                         | 25D. ADDRESS<br><b>1216 S. Charles St.</b>   |                                    |  |  |





F-5201

69 10536

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

69 10536

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                         |   |  |  |  |
|---|-------------------------|---|--|--|--|
| BIRTH NO.   |                         | 1. NAME OF DECEASED<br>(Type or Print) <i>Alice D. ENNOSS</i>   |  | 2. DATE AND HOUR OF DEATH<br><i>10-24-69</i> <i>2:55</i> P.M.            |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                         |   | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <i>MARYLAND</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>Baltimore #28</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>6102 Collinsway Rd.</i> |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>Lutheran Hospital</i>  |                         |   | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |  |  |
| 5. SEX<br><i>Female</i>   | 6. RACE<br><i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>1889</i>  | 9. AGE (In years last birthday)<br><i>79</i>                             | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.    |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>   |                         | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><i>Baltimore, Maryland</i>  |  |
| 13. FATHER'S NAME<br><i>Jeremiah Maher</i>  |                         |   | 14. MOTHER'S MAIDEN NAME<br><i>Ella Delaney</i>  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>Unknown</i>  |                         | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><i>Mrs. Eileen E. Gill, 6102 Collinsway Rd.</i>         |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><i>Pneumonia, RUL</i><br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><i>arteriosclerotic cardiovascular disease</i> |                         |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>acute</i>   |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                         |   |  |  |  |
| 19A. DATE OF OPERATION<br><i>0</i>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><i>X</i>                                    |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>19</i> to <i>19</i> , that (I) (we) last saw the deceased alive on <i>19</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                         |   |  |  |  |
| 23A. SIGNATURE<br><i>In Gayoso</i>  |                         |   | 23B. DATE SIGNED<br><i>10/24/69</i>  |  | 23C. PHYSICIAN'S NAME (Type)<br><i>Robert E. Taylor M.D.</i> |
| 23D. ADDRESS  |                         |   | 23E. ADDRESS   |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |                         | 24B. DATE<br><i>Oct. 27, 1969</i>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><i>St. Peters Cemetery</i>         |  |
| 24D. LOCATION (City, town, or county) (State)<br><i>Baltimore, Maryland</i>   |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><i>OCT 28 1969</i>   |  |  |  |
| 25B. NAME OF REGISTRAR<br><i>Robert E. Taylor M.D.</i>  |                         | 25C. FUNERAL DIRECTOR<br><i>G. Truman Schwab, 5151 Balto. Natl. Pike, Baltimore, Maryland, 21229</i>  |  |  |  |



2-5351

69 10537

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

69 10537

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

LINTWINCZUK, WASILI J.

2. DATE AND HOUR OF DEATH

10-24-69 1:20 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)FRANKLIN SQUARE HOSP.  
36 110 N. CALHOUN ST.  
BALTO., 23, MD.

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

BALTIMORE CO 53-00

C. CITY OR TOWN

BALTO. MD.

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

315 SHADY NOOK AVE.

5. SEX

M

6. RACE

WHITE

7. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

8/4/189

9. AGE (in years  
last birthday)

80

If Under 1 Yr.

Months

If Under 24 Hrs.

Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

RUSSIA

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

JOHN LINTWINCZUK

14. MOTHER'S MAIDEN NAME

EDNA ELESKO

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

705-03-9598

17. INFORMANT

Hospital Records

ADDRESS

18.

41221

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.Uremia secondary to vascular disease  
(A) IMMEDIATE CAUSE of Kidney  
DUE TO, OR AS A CONSEQUENCE OF:(B) H. Pylorophitis and dissecting Aneurysm  
of abd. aorta  
DUE TO, OR AS A CONSEQUENCE OF:(C) Hypertension and art. sclerotic Cardio  
DUE TO, OR AS A CONSEQUENCE OF:

Vascular disease

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (nally medical examined)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10/19/1969 to 10/24/1969  
that (I) (we) last saw the deceased alive on 10/24/1969 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

A. Chittchang

DEGREE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

10/24/69

23C. PHYSICIAN'S  
NAME (Type)

A. Chittchang (M.D.)

DEGREE

23D. ADDRESS

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

10/29/69

24C. NAME OF CEMETERY OR CREMATORY

Holy Trinity Ind. Bur. Orth.

24D. LOCATION

(City, town, or county)

(State)

6220 Elibank Rd. Howard Md.

25A. DATE REC'D BY HEALTH DEPT.

OCT 28 1969

25B. NAME OF REGISTRAR

Robert E. Jorgensen M.D.

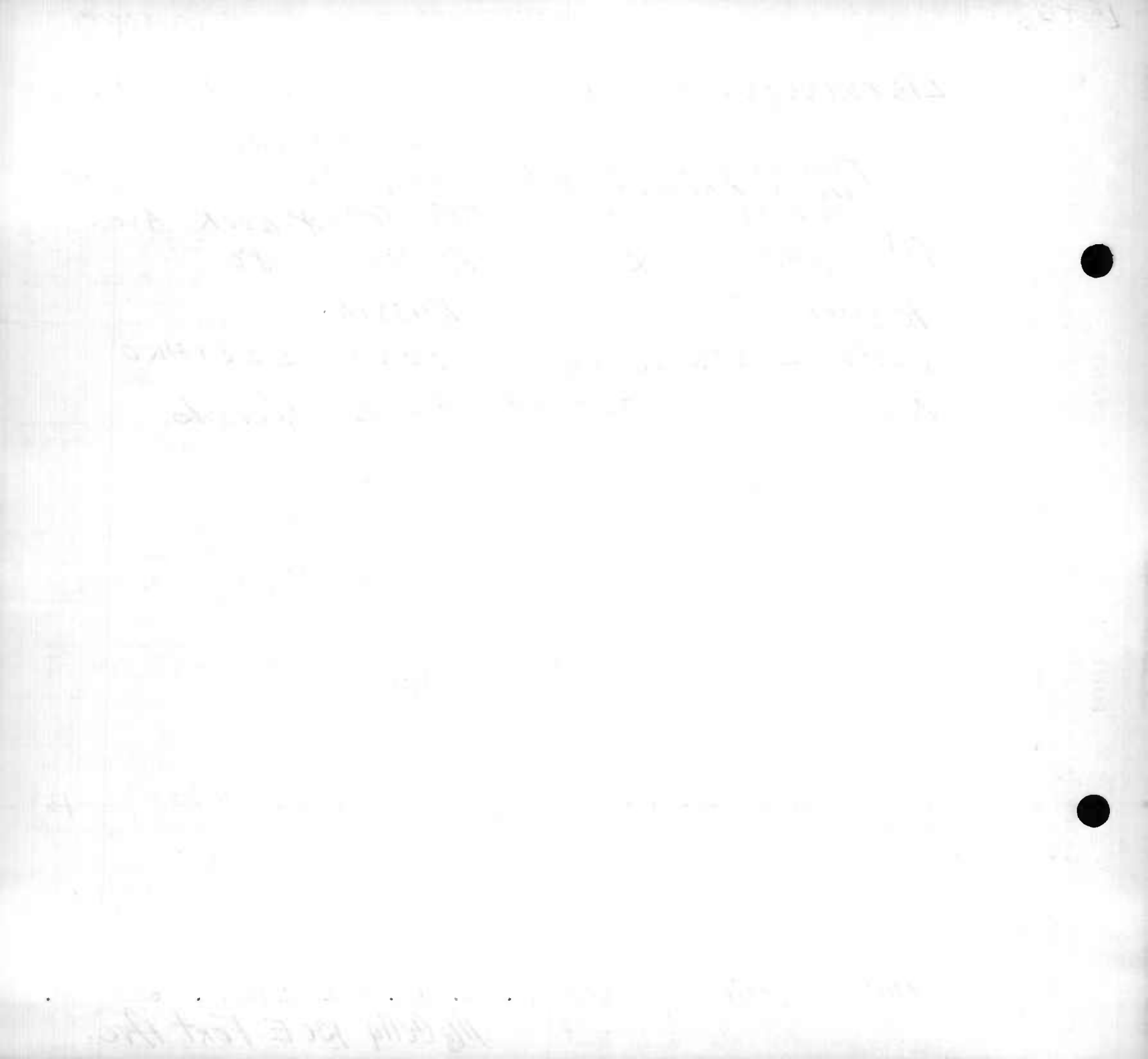
25C. FUNERAL DIRECTOR

McGilly 430 E. Fort Ave.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

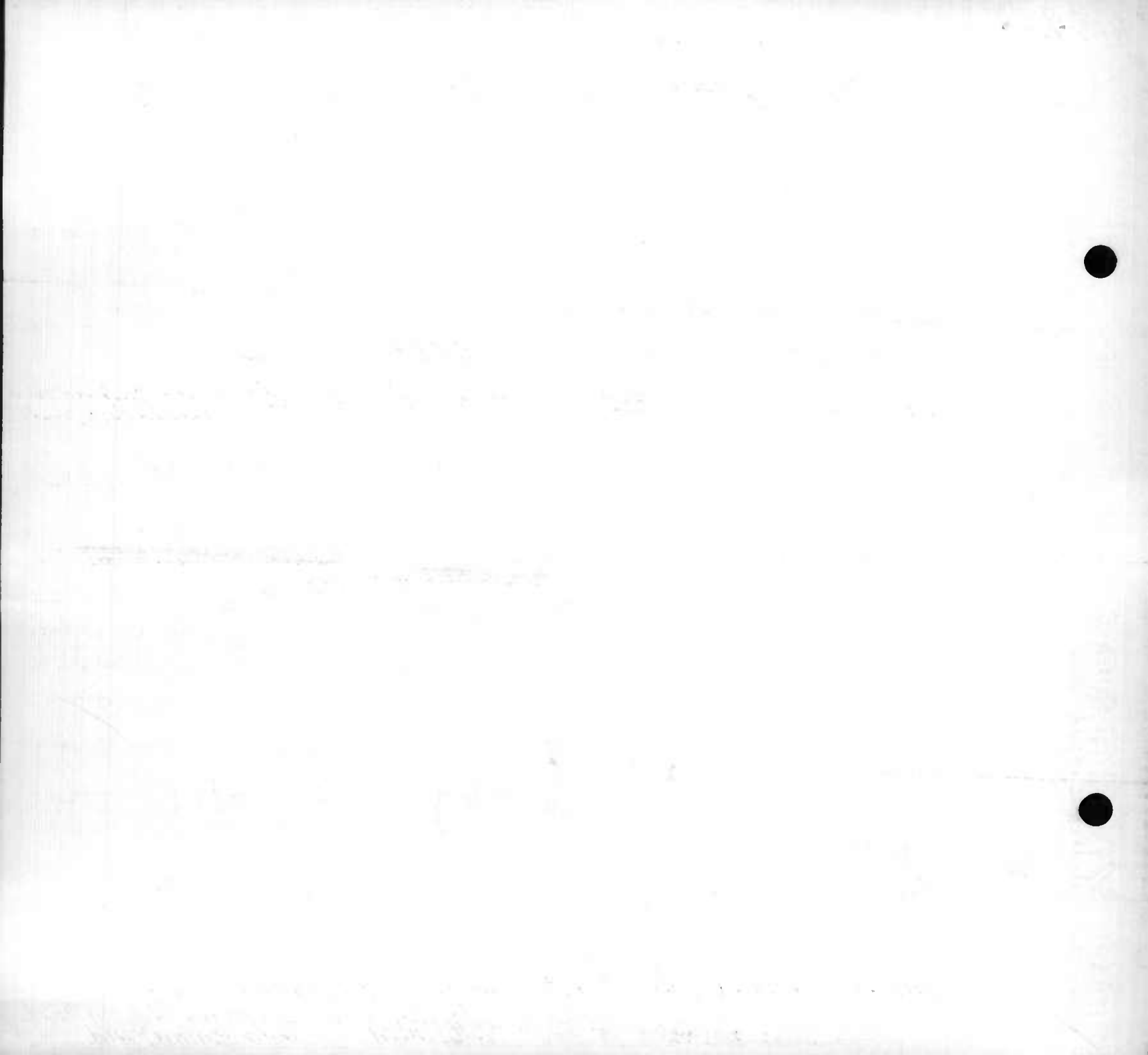
R-593 1

69 10538

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 10538

|  |                     |   |  |
|--|---------------------|---|--|
| BIRTH NO.  |                     | 69 10538  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Reynolds, Herman Perry Jr.</i>   |                     | 2. DATE AND HOUR OF DEATH<br><i>Oct 25, 1969 12:08 A.M.</i>   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><i>Maryland General Hospital</i>   |                     | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <i>MD</i> B. COUNTY <i>Balto. City</i>                    |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>Maryland General Hospital</i>   |                     | C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                              |  |
| IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION   |                     | E. STREET AND NUMBER<br><i>1 W. Franklin St.</i>  |  |
| 5. SEX<br><i>M</i>   | 6. RACE<br><i>W</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>09-23-21</i>          |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Balto. News-American</i>   |                     | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Newspaper</i>   | 9. AGE (In years last birthday)<br><i>48</i> |
| 11. BIRTHPLACE (State or foreign country)<br><i>Georgia</i>  |                     | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  |
| 13. FATHER'S NAME<br><i>M. Perry Reynolds Sr.</i>  |                     | 14. MOTHER'S MAIDEN NAME<br><i>Mamma Dickinson</i>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>No Not a veteran</i>  |                     | 16. SOCIAL SECURITY NO.<br><i>233-26-8195</i>   |  |
| 17. INFORMANT<br><i>Mrs. Don Reynolds (wife)</i>   |                     | ADDRESS<br><i>433 B. W. Dr. W. Severna Park, Md.</i>  |  |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><i>HEPATIC FAILURE</i><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><i>CIRRHOSIS Nutritional</i><br><i>ANEMIA 20 to 30</i><br><i>? Intestinal Age Gastritis or Varicella</i> |                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| MEDICAL CERTIFICATION<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br>19A. DATE OF OPERATION<br><i>0</i>  |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20A. AUTOPSY? (Yes or No)<br><input checked="" type="checkbox"/>   |                     | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><i>Water</i>  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)<br><input type="checkbox"/>   |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |
| 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)  |                     | 21D. TIME OF INJURY (Approx.)<br>[Month] [Day] (Year) (Hour)  |  |
| 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                     | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>10/22</i> 19 <i>69</i> to <i>10/25</i> 19 <i>69</i> and that (I) (we) last saw the deceased alive on <i>10/25</i> 19 <i>69</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                     |   |  |
| 23A. SIGNATURE<br><i>Enrique A. M.D.</i>   |                     | 23B. DATE SIGNED<br><i>10/25/69</i>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><i>ENRIQUE, A.</i>   |                     | 23D. ADDRESS<br><i>MARYLAND GEN. HOSP.</i>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |                     | 24B. DATE<br><i>10/26/69</i>  |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><i>Hill Crest Cemetery</i>   |                     | 24D. LOCATION<br><i>SAVANNAH GA.</i>  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>OCT 28 1969</i>  |                     | 25B. NAME OF REGISTRAR<br><i>Robert E. Barber, M.D.</i>   |  |
| 25C. FUNERAL DIRECTOR<br><i>Singleton Funeral Home</i>   |                     | ADDRESS<br><i>Calver Avenue, Md.</i>  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

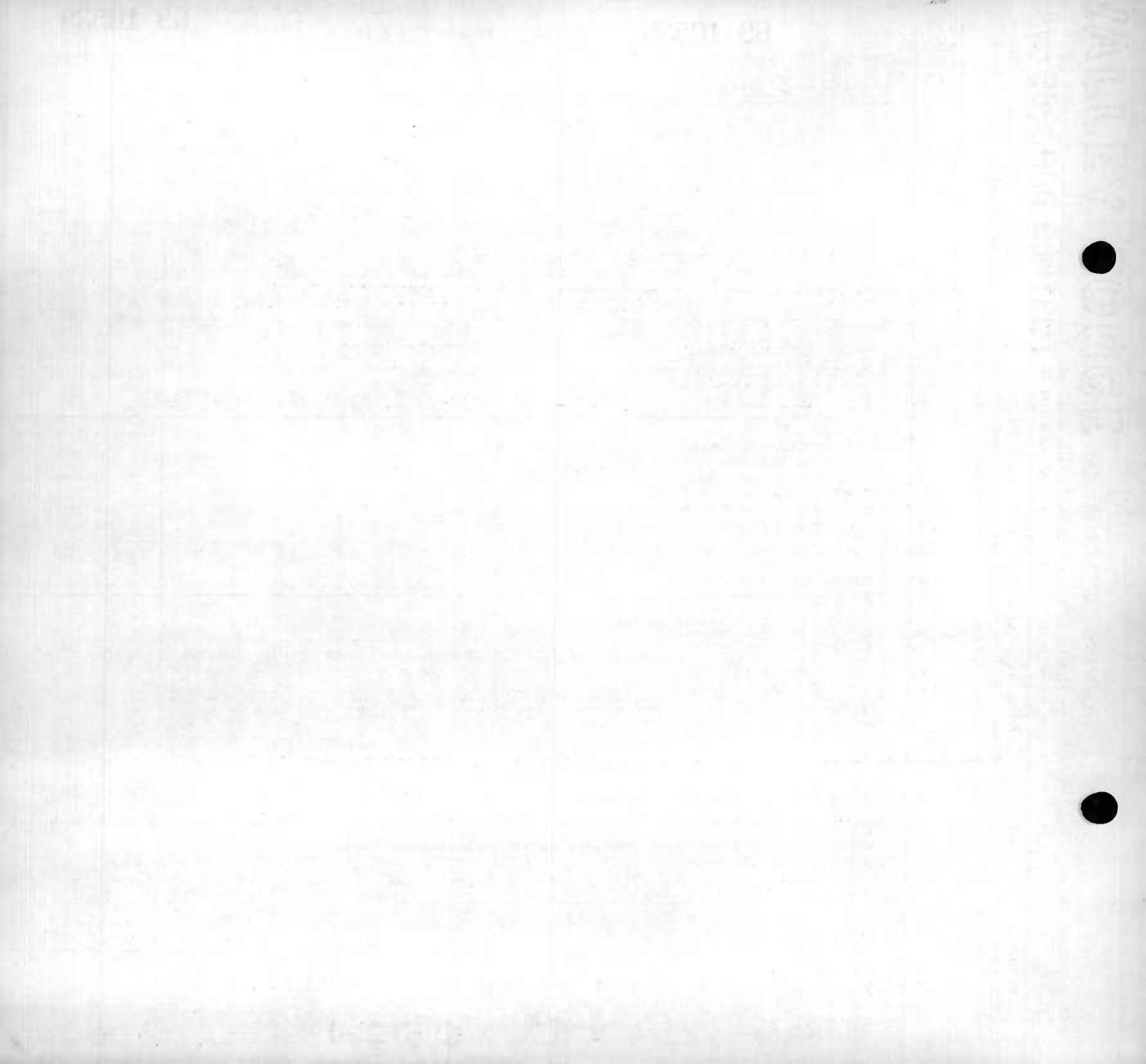
69 10539

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

69 10539

|  |                          |  |   |  |  |
|--|--------------------------|--|---|--|--|
| BIRTH NO.  |                          | 1. NAME OF DECEASED<br>(Type or Print) <b>JOHN E. STEERS</b>   |   | 2. DATE AND HOUR OF DEATH<br><b>10/27/69</b> <b>5<sup>30</sup></b> M.                              |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                          |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD</b> B. COUNTY <b>MD</b> |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>UNION MEMORIAL HOSPITAL BALT. MD</b>  |                          |  | C. CITY OR TOWN <b>BETHLEHEM</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                |  |  |
|  |                          |  | E. STREET AND NUMBER <b>4540 MARBLE HALL RD 2739</b>  |  |  |
| 5. SEX <b>MALE</b>   | 6. RACE <b>CAUCASIAN</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH <b>9/23/884</b>   | 9. AGE (In years last birthday) <b>85</b>                |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Machinist</b>  |                          | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Bethlehem Steel Co</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Bethlehem, Pa.</b>                                 |  |
| 13. FATHER'S NAME<br><b>Edward Steer</b>   |                          |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                          |  | 16. SOCIAL SECURITY NO.<br><b>171-09-3071</b>   |  | 17. INFORMANT<br><b>Mildred S. Smith (Daughter) Same</b> |
| 18. <b>436.9 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>CARDIO - RESPIRATORY ARREST</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>CUA</b> |                          |  | CAUSE OF DEATH<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |                          |  |   |  |  |
| 19A. DATE OF OPERATION <b>0</b>  |                          | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No) <b>NO</b>  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                          | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                           |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  |                          | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |   | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10/24</b> 19 <b>69</b> to <b>10/27</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>10/24</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                          |  |   |  |  |
| 23A. SIGNATURE<br><b>ROBERT M. LEGG M.D.</b>   |                          |  |   | 23B. DATE SIGNED<br><b>10/29/69</b>  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>ROBERT M. LEGG M.D.</b>   |                          |  |   | 23D. ADDRESS<br><b>Union Memorial Hospital Balt MD</b>   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                          | 24B. DATE<br><b>10/27/69</b>   |   | 24C. NAME OF CEMETERY or CREMATORY<br><b>Memorial Park Cemetery</b>                                |  |
|  |                          |  |   | 24D. LOCATION (City, town, or county) (State)<br><b>Bethlehem, Pa</b>                              |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 28 1969</b>  |                          | 25B. NAME OF REGISTRAR<br><b>Robert E. Jaffer M.D.</b>   |   | 25C. FUNERAL DIRECTOR<br><b>Eugenia K. Seitz 5209 York Rd. Seitz Funeral Home Balto. Md. 21212</b> |  |





m-550

BALTIMORE CITY HEALTH DEPARTMENT

69 10540 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 10540

BIRTH NO.

REG. NO.

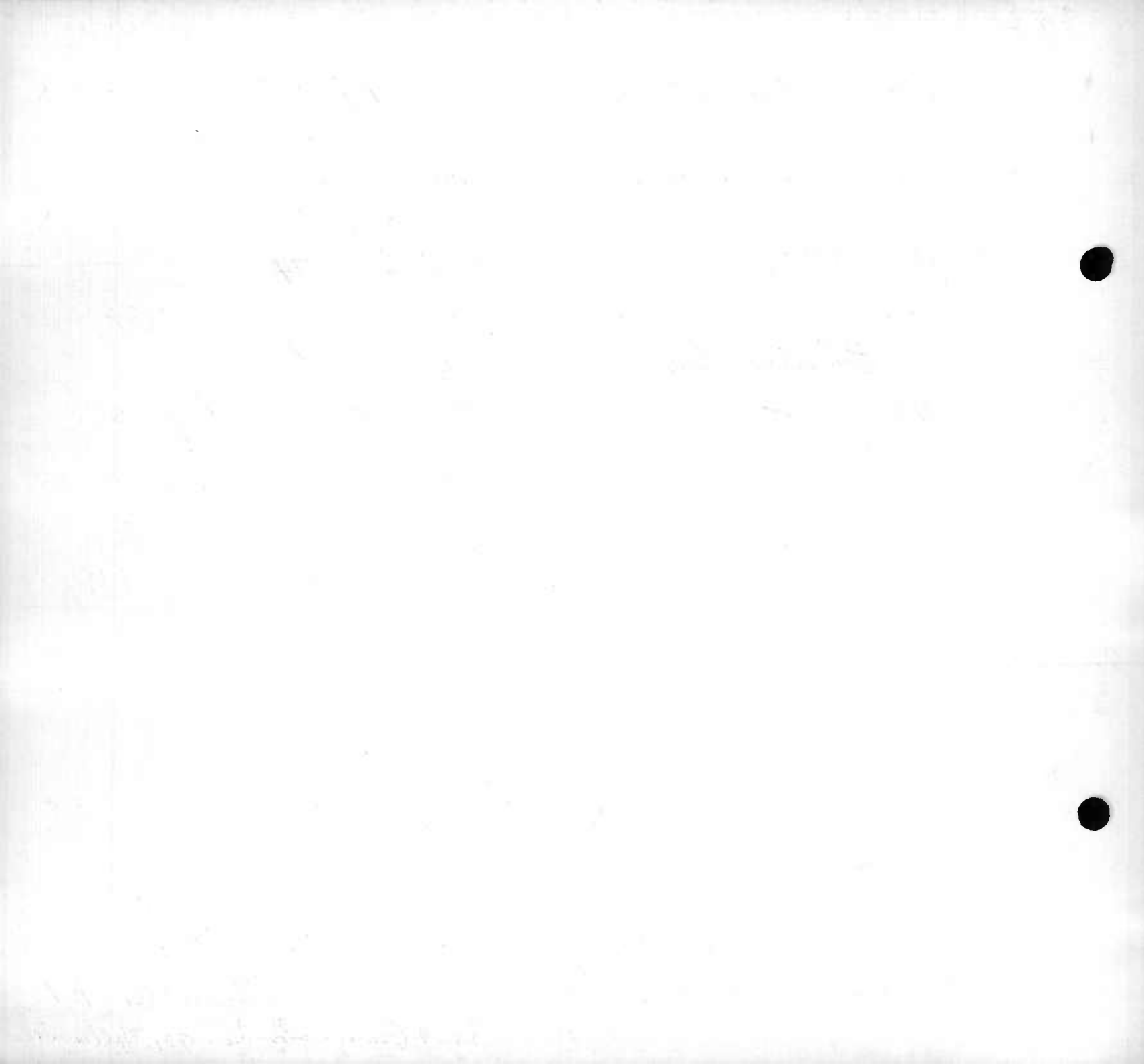
|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>DOROTHY E. MANNONE</b>   |  |   |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> <b>10 23 69 4:50 p M.</b> |  |   |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME (If not in hospital or institution, give street, house or apartment number, and location)<br><b>1400 Kuper Place</b><br><b>2-17-71</b>  |  |   |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>Oct. 23, 1969 4:50 p M.</b>  |  |   |  |
| 6. SEX<br><b>Female</b>   |  |   |  | 7. RACE<br><b>White</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. DATE OF BIRTH<br><b>August 18, 1929</b>  |  |   |  | 10. AGE (In years last birthday)<br><b>40</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  | 13. FATHER'S NAME<br><b>Albert Z. Ringer</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Regina Schwollow</b>   |  |
| 15. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>1902</b>   |  |   |  | 16. CITY OR TOWN<br><b>Balto.</b>   |  |   |  |
| 17. D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  | 18. STREET AND NUMBER<br><b>1400 Kuper Place</b>  |  |   |  |
| 19. 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  |   |  | 14B. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |  |   |  | 17. SOCIAL SECURITY NO.<br><b>214-30-1065</b>   |  | 18. INFORMANT ADDRESS<br><b>Angelo Mannone 1400 Kuper Pl. 21223</b>   |  |
| 19. CAUSE OF DEATH<br><b>571.8</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>(A) IMMEDIATE CAUSE <del>Fatty liver</del> Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>(B) _____</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>(C) _____</b>   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>Chronic alcoholism with fatty liver</b>  |  |   |  |   |  |   |  |
| 20A. DATE OF OPERATION<br><b>2</b>  |  |   |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 21. AUTOPSY? (Yes or No)<br><b>YES</b>  |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.<br><input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING   |  |   |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?  |  |
| 22D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)<br><b>2</b>  |  |   |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 22F. HOW DID INJURY OCCUR?  |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Isidore Mihalakis, M.D.</b> M.D.<br>EXAMINER'S NAME (Type)<br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED <b>Oct. 24, 1969</b> |  |   |  |   |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 24B. DATE<br><b>10/27/69</b>                            |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Glen Haven Mem. Park</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>Anne Arundel Co. Maryland</b>   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 28 1969</b>   |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Sailer, M.D.</b> |  | 25C. FUNERAL DIRECTOR<br><b>Walters Funeral Home</b>  |  | ADDRESS<br><b>Pratt &amp; Stricker Sts.</b>   |  |

Letter from M.E.'s office 2-17-71 M.H.  
1/15/71  
received too late to charge under  
of death for 1969 yr

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| 69 10541  |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | REG. NO. 69 10541   |  |
|---|--|--|--|---|--|
| BIRTH NO.   |  | 1. NAME OF DECEASED<br>(Type or Print) <b>ARTHUR RAYMOND COX</b>   |  | 2. DATE AND HOUR OF DEATH<br><b>10/25/69 5:00 A.M.</b>  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD</b> B. COUNTY <b>BALTIMORE</b>                   |  | 5. SEX <b>M</b> 6. RACE <b>WHITE</b>  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>UNIV. MARYLAND HOSP</b><br><b>38</b>   |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |  | C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| E. STREET AND NUMBER<br><b>1005 BOYD ST</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>2/6/95</b> 9. AGE (In years lost birthday) <b>74</b>  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>MACHINIST</b>   |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>TOOL Co.</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>W. VA.</b>  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 13. FATHER'S NAME<br><b>Charles Cox</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>ALICE ?</b>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |  | 16. SOCIAL SECURITY NO.<br><b>-</b>  |  | 17. INFORMANT<br><b>JAMES COX</b> ADDRESS<br><b>1005 Boyd ST.</b>   |  |
| 18. <b>431.9 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>BRAIN STEM HEMORRHAGE</b><br><b>COMA</b><br><b>CARDIAC &amp; RESP ARREST</b> |  | CAUSE OF DEATH   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>36 HRS</b><br><b>36 h</b><br><b>1 h</b>                                  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |  |  |   |  |
| 19A. DATE OF OPERATION<br><b>2/2</b>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)<br><b>Yes</b>   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>Yes</b>                                      |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)<br><b>10/24/69</b>  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10/24/69</b> 19 <b>64</b> to <b>10/25</b> 19 <b>69</b> and that (I) (we) last saw the deceased alive on <b>10/25</b> 19 <b>69</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |  |  |  |   |  |
| 23A. SIGNATURE<br><b>Howard Wallach M.D.</b>  |  | 23B. DATE SIGNED<br><b>10/25/69</b>  |  | 23C. PHYSICIAN'S NAME (Type)<br><b>HOWARD WALLACH, M.D.</b>   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 24B. DATE<br><b>10/28/69</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Crest Lawn Cem</b>   |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Howard Co. Md.</b>  |  | 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 28 1969</b>  |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>   |  |
| 25C. FUNERAL DIRECTOR<br><b>John J. Conway</b>  |  | 25D. ADDRESS<br><b>901 Thelma St</b>   |  |   |  |



FUNERAL DIRECTOR: IMPORTANT

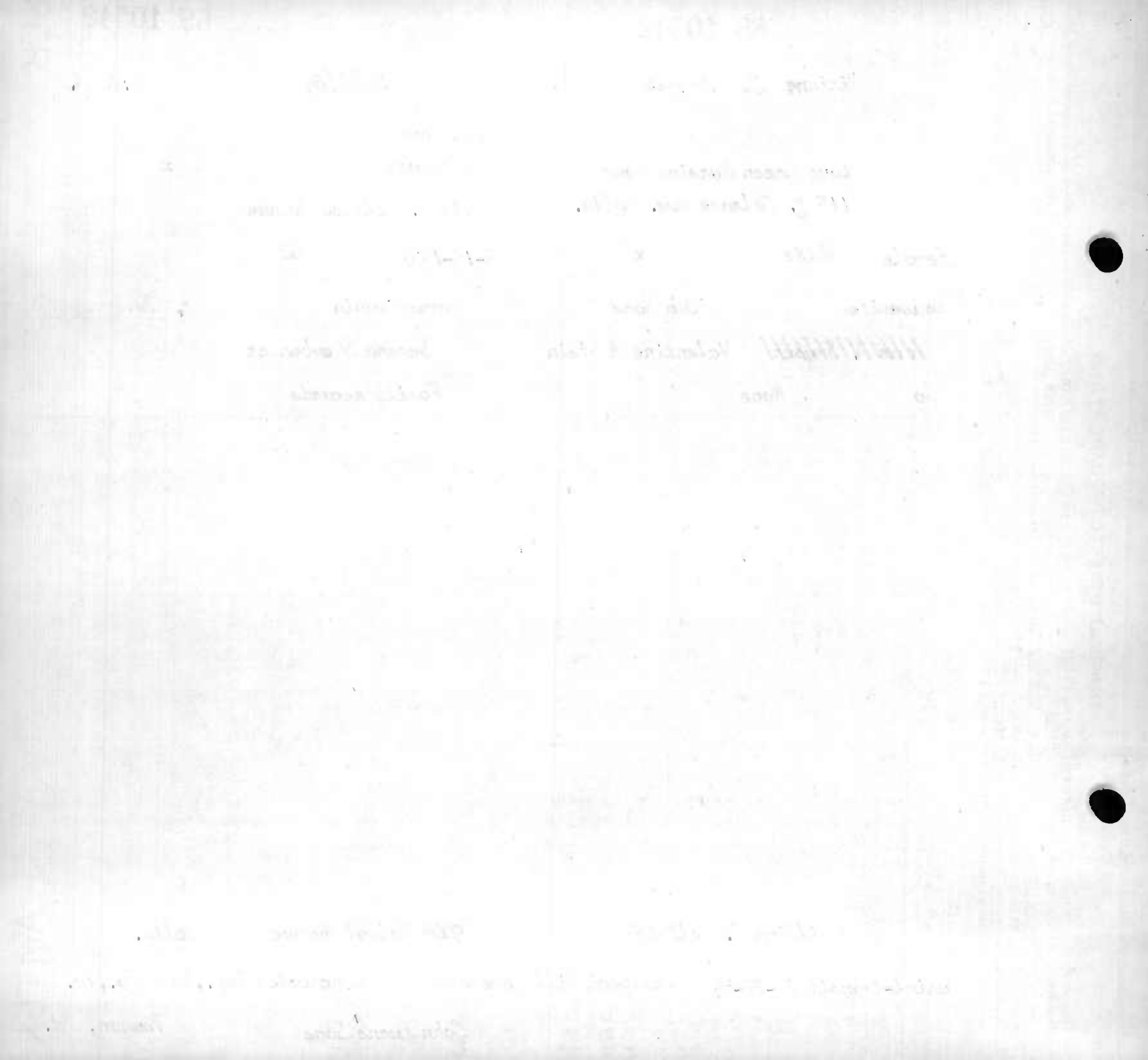
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 10542

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 10542

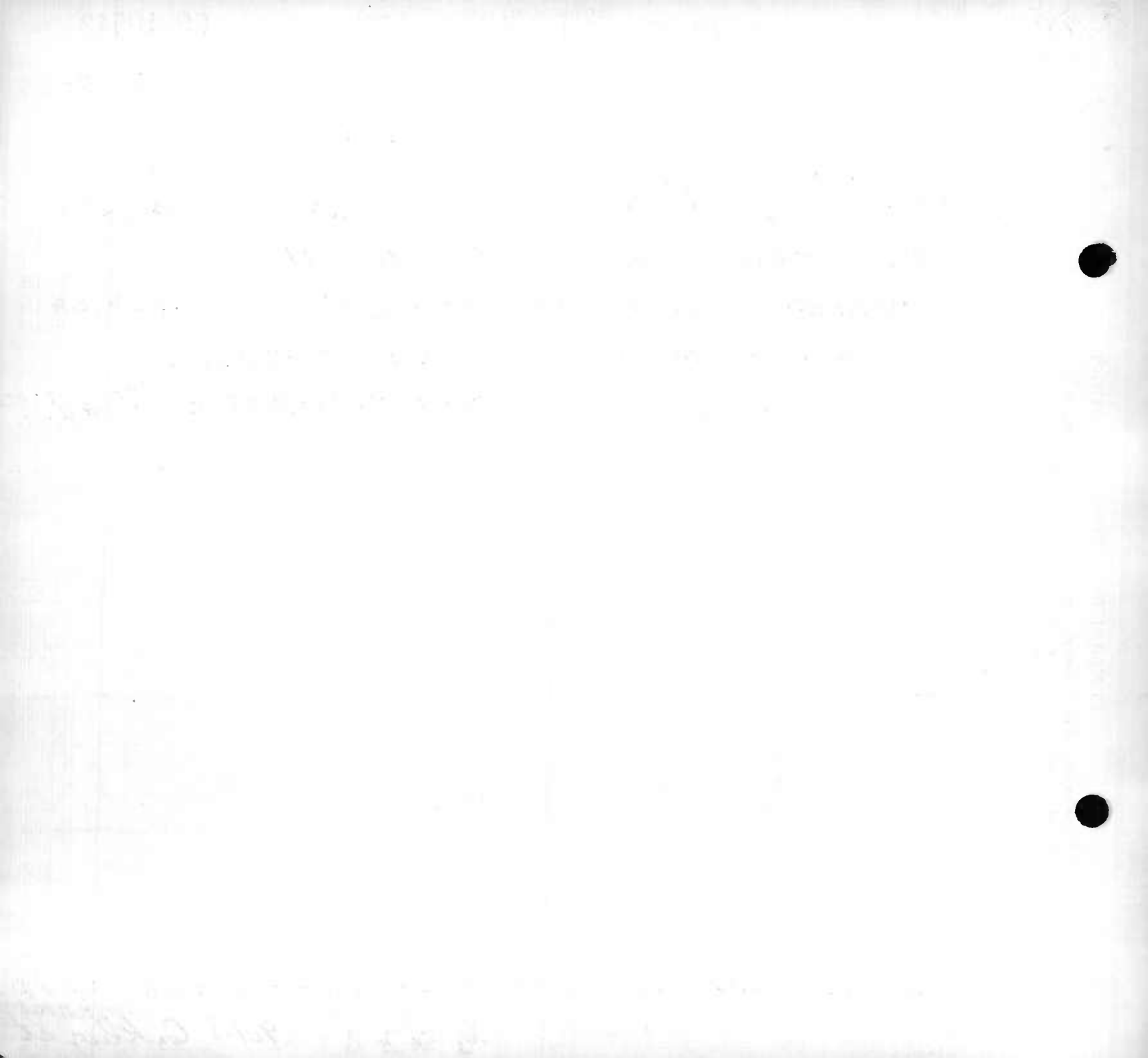
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|--|--|--|--|---|--|
| BIRTH NO.  |  | 1. NAME OF DECEASED<br>(Type or Print) <i>Miriam S. Smyser</i>   |  | 2. DATE AND HOUR OF DEATH<br><i>10/24/69</i>   <i>3:10 A.</i> M.  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Maryland</i><br>B. COUNTY <i>27/2</i>                  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>90 Long Green Nursing Home</i><br><i>115 E. Melrose Ave. Balto.</i>   |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |  | C. CITY OR TOWN <i>Baltimore</i><br>D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                           |  |
| 5. SEX<br><i>Female</i>  |  | 6. RACE<br><i>White</i>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>  |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Own Home</i>   |  | 8. DATE OF BIRTH<br><i>5-15-1887</i>  |  |
| 13. FATHER'S NAME<br><i>Adah/Mr./Shlyshel/ Valentine A Stein</i>   |  | 14. MOTHER'S MAIDEN NAME<br><i>Serena Shenberger</i>   |  | 9. AGE (In years lost birthday)<br><i>82</i><br>If Under 1 Yr. Months: Days: Hours: Min.  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, or unknown) (If yes, give year or dates of service)<br><i>No</i>  |  | 16. SOCIAL SECURITY NO.<br><i>None</i>   |  | 11. BIRTHPLACE (State or foreign country)<br><i>Pennsylvania</i><br>12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  |
| 17. INFORMANT<br><i>Family records</i>   |  | ADDRESS  |  |   |  |
| 18. <i>436.9 I</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><i>II</i><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><i>Stroke</i> |  | CAUSE OF DEATH<br><i>Arteriosclerosis</i><br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF: |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 19A. DATE OF OPERATION<br><i>0</i>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)   |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12 Nov 19 69</i> to <i>24 Oct 19 69</i> .<br>that (I) (we) last saw the deceased alive on <i>Oct 19 69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.   |  |  |  |   |  |
| 23A. SIGNATURE<br><i>William G. Helfrich</i><br>DEGREE   |  | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>  |  | 23B. DATE SIGNED<br><i>10-24-69</i>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><i>William G. Helfrich</i><br>DEGREE   |  | 23D. ADDRESS<br><i>5006 Roland Avenue Balto.</i>   |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial-transit</i>  |  | 24B. DATE<br><i>10-27-69</i>   |  | 24C. NAME of CEMETERY or CREMATORY<br><i>Prospect Hill Cemetery</i>   |  |
| 24D. LOCATION (City, town, or county) (State)<br><i>Manchester Twp., York Co., Pa.</i>   |  | 25A. DATE REC'D BY HEALTH DEPT.<br><i>OCT 28 1969</i>  |  |   |  |
| 25B. NAME OF REGISTRAR<br><i>Robert E. Faiber, M.D.</i>  |  | 25C. FUNERAL DIRECTOR<br><i>John Burns Sons</i>  |  | ADDRESS<br><i>Towson, Md.</i>   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                  |  |  |  |  |
|--|------------------|--|--|--|--|
| 69 10543   |                  | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH   |  | REG. NO. 69 10543  |  |
| BIRTH NO.  |                  | 1. NAME OF DECEASED<br>(Type or Print) MRS. MARY C. SCHAEFER   |  | 2. DATE AND HOUR OF DEATH<br>10/24/69 11:50 A.M.   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                  |  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE MARYLAND B. COUNTY |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>CHURCH HOME & HOSPITAL<br>BALTIMORE, MARYLAND  |                  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |  | C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
|  |                  |  |  | E. STREET AND NUMBER<br>6729 ROBERTS AVE. #21224   |  |
| 5. SEX<br>FEMALE   | 6. RACE<br>WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br>8/29/81  | 9. AGE (In years last birthday)<br>88 yrs. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>RETIRED   |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>HOUSE WORK  |  | 11. BIRTHPLACE (State or foreign country)<br>BALTO., MD.   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br>AMERICA.   |                  | 13. FATHER'S NAME<br>ANDREW MAIN   |  |  |  |
| 14. MOTHER'S MAIDEN NAME<br>CLARA RATHELL  |                  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO   |  |  |  |
| 16. SOCIAL SECURITY NO.  |                  | 17. INFORMANT<br>MRS. ADELAID M. NETRO   |  |  |  |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>CARDIORESPIRATORY FAILURE<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>ASCVD, CHF, CARDIAC ARRHYTHMIA.<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>AZOTEMIA, BLEEDING GI AND PLEURAL EFFUSION<br>(C) |  |  |  |
| 19A. DATE OF OPERATION   |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |
| 21D. TIME OF INJURY (APPROX.)  |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from 10/20/69 to 10/24/69 and that (I) (we) last saw the deceased alive on 10/24/69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                  |  |  |  |  |
| 23A. SIGNATURE<br>A. E. CHOUVALIT, M.D.  |                  |  |  | 23B. DATE SIGNED<br>10/24/69   |  |
| 23C. PHYSICIAN'S NAME (Type)<br>A. E. CHOUVALIT, M.D.  |                  |  |  | 23D. ADDRESS<br>CHURCH HOME & HOSPITAL<br>BALTO., MD.  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>BURIAL   |                  | 24B. DATE<br>10-27-69  |  | 24C. NAME of CEMETERY or CREMATORY<br>SACRED HEART CEM.  |  |
| 24D. LOCATION<br>7401 GERMAN HILL RD. BALCO., MD.  |                  | 25A. DATE REC'D BY HEALTH DEPT.<br>OCT 28 1969   |  |  |  |
| 25B. NAME OF REGISTRAR<br>P. E. Fisher, M.D.   |                  | 25C. FUNERAL DIRECTOR<br>Gerald Zeiden - 901 S. Conkling St.   |  |  |  |





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 10544

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

69 10544

|   |                      |   |   |   |   |   |  |  |  |
|---|----------------------|---|---|---|---|---|--|--|--|
| BIRTH NO.   |                      | 69 10544  |   | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH  |   | REG. NO.  |  | 69 10544   |  |
| 1. NAME OF DECEASED<br>(Type or Print)<br>Carlton W. Todd   |                      |   |   | 2. DATE AND HOUR OF DEATH<br>10-26-69 8:03 AM   |   |   |  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION<br>40 St. Agnes Hospital<br>Caton & Wilkens Avenue<br>BALTIMORE, Maryland  |                      |   |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland B. COUNTY 21229<br>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER 3643 Coolidge Avenue |   |   |  |  |  |
| 5. SEX<br>Male  | 6. RACE<br>Caucasian | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>5-26-95                             | 9. AGE (In years last birthday)<br>74   | If Under 1 Yr. Months Days                            |   | If Under 24 Hrs. Hours Min.            |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Retired Rate Aut.  |                      |   | 10B. KIND OF BUSINESS OR INDUSTRY<br>Elliott Bro. Truck |   | 11. BIRTHPLACE (State or foreign country)<br>Maryland |   | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A. |  |  |
| 13. FATHER'S NAME<br>Francis Todd   |                      |   |   | 14. MOTHER'S MAIDEN NAME<br>Florance (Unknown)  |   |   |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>Yes   |                      | 16. SOCIAL SECURITY NO.<br>W W I 212-10-5539  |   | 17. INFORMANT<br>Mrs. Edna L. Todd, 3643 Coolidge Ave. 21229  |   |   |  |  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>4109 I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>Acute Coronary occlusion<br>DUE TO, OR AS A CONSEQUENCE OF:<br>ASCVD<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) Euphysema<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 1/2 hours<br>? |                      |   |   |   |   |   |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br>19A. DATE OF OPERATION<br>0   |                      |   |   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                         |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  |
| 21F. HOW DID INJURY OCCUR?  |                      | 21G. HOW DID INJURY OCCUR?  |   | 21H. HOW DID INJURY OCCUR?  |   | 21I. HOW DID INJURY OCCUR?  |  | 21J. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from April 1966 to Oct 26 1969 that (I) (we) last saw the deceased alive on Oct 26 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |                      |   |   |   |   |   |  |  |  |
| 23A. SIGNATURE<br>Earl Pass   |                      |   |   | 23B. DATE SIGNED<br>10/26/69  |   | 23C. PHYSICIAN'S NAME (Type)<br>I. Earl Pass                                      |  | 23D. ADDRESS<br>4001 Wilkens Avenue 21229  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |                      | 24B. DATE<br>10-29-69   |   | 24C. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Cemetery  |   | 24D. LOCATION (City, town, or county) (State)<br>Washington Blvd. Howard Co., Md. |  | 24E. LOCATION (City, town, or county) (State)  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>OCT 28 1969  |                      | 25B. NAME OF REGISTRAR<br>Robert E. Taylor, M.D.  |   | 25C. FUNERAL DIRECTOR<br>Howard H. Hubbard  |   | 25D. ADDRESS<br>4107 Wilkens Ave. 21229   |  | 25E. ADDRESS   |  |

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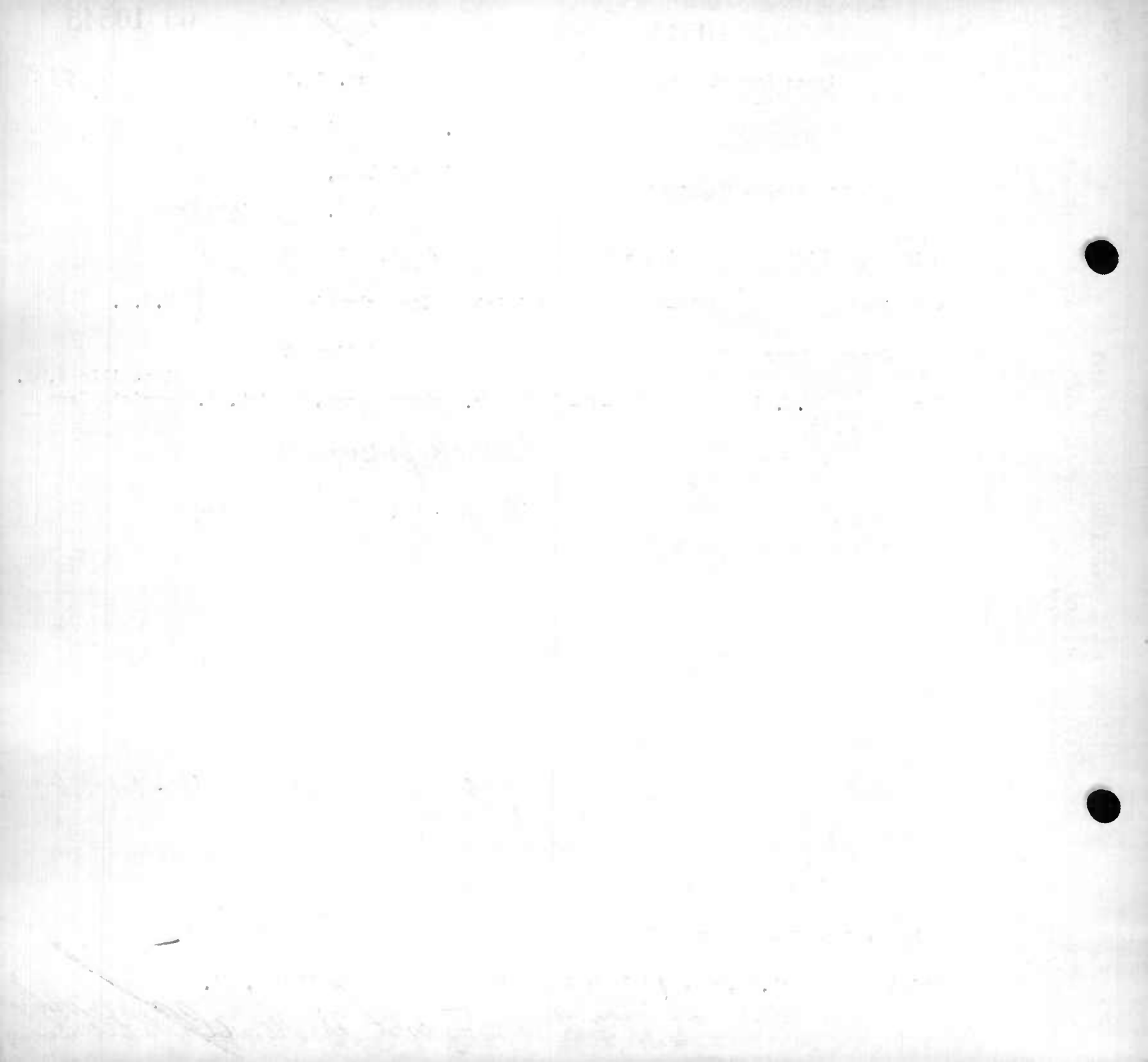
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|--|--|---|
| BIRTH NO.<br>69 10545  |  | BALTIMORE CITY HEALTH DEPARTMENT<br>REGISTERED NO. 69 10545  |   |
| M.E. CASE NO.<br>1. NAME OF DECEASED<br>(Type or Print)<br><b>Cyrus Leport Rhone</b>   |  | 2. DATE AND HOUR OF DEATH<br><b>Oct. 17, 1969</b> <b>2:55 P.M.</b>   |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>36 Franklin Square Hospital</b><br>(If not in hospital or institution, give street address or location)   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>Baltimore Co</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Pikesville 8,</b><br>D. STREET ADDRESS (If rural, give location) <b>Old Court Rd. &amp; Marriott Lane</b> |   |
| 5. SEX<br><b>Male</b>  | 6. RACE<br><b>White</b>  | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>Divorced</b>  | 8. DATE OF BIRTH<br><b>March 31, 1892</b>                             |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>  |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Self-employed Machinist</b>  | 9. AGE (In years last birthday)<br><b>77</b>                          |
| 13. FATHER'S NAME<br><b>Jesse Rhone</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Adeline ?</b>   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes W.W. 1</b>  |  | 16. SOCIAL SECURITY NO.<br><b>205-03-2157</b>  |   |
| 17. INFORMANT<br><b>Mr. Robert Rhone, Old Crt. Rd. &amp; Marriott Lane</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><b>440.9 I</b><br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Bronchopneumonia -</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Generalized arteriosclerosis</b> |  | INTERVAL BETWEEN ONSET AND DEATH   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |  |   |
| 19A. DATE OF OPERATION   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20A. AUTOPSY? (Yes or No)  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10-2</b> 19 <b>69</b> to <b>10-17</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>10-17</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |  |  |   |
| 23A. SIGNATURE<br><b>R. Perez-Mera</b>   |  | 23B. DATE SIGNED   |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>R. PEREZ-MERA</b>   |  | 23D. ADDRESS<br>M.D. <b>8507 LIBERTY RD</b>  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 24B. DATE<br><b>Oct. 20, 1969</b>  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Woodlawn Cemetery</b>   | 24D. LOCATION (City, town, or county) (State)<br><b>Woodlawn, Md.</b> |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 28 1969</b>  |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>  |   |
| 25C. FUNERAL DIRECTOR<br><b>Frank D. Newell, Pikesville</b>  |  | ADDRESS  |   |



BIRTH NO. **69 10546** MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. **69 10546**

|   |  |  |  |
|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Lillie A. Martin</b>  |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month <b>10</b> Day <b>18</b> Year <b>69</b> Hour <b>11:30 p.m.</b><br>Estimated <input type="checkbox"/>  |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>42 Sinai Hospital</b>  |  | 3. DATE PRONOUNCED DEAD<br>Month <b>10</b> Day <b>18</b> Year <b>69</b> Hour <b>11:30 p.m.</b>   |  |
| 6. SEX<br><b>female</b>   |  | 7. RACE<br><b>white</b>  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> <b>SEPARATED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | C. CITY OR TOWN<br><b>Baltimore</b>  |  |
| 9. DATE OF BIRTH<br><b>Jan. 24, 1895</b>  |  | 10. AGE (In years lost birthday) <b>74</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Gwynedd, Md.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>GEORGE HARE</b>   |  | 14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>2788</b>   |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>   |  | 14B. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>   |  |
| 15. MOTHER'S MAIDEN NAME<br><b>ELSIE WILHELM</b>  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO NONE</b>  |  |
| 17. SOCIAL SECURITY NO.<br><b>220-03-4336</b>   |  | 18. INFORMANT<br><b>W. OLIN HARE, 5215 ST. CHARLES AVE., Md.</b>   |  |
| 19. CAUSE OF DEATH<br><b>E9531X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Metabolic acidosis</b><br><b>Asphyxia with plastic bag</b><br><b>Ingestion of Methapyrilene ?</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |  |  |
| 20A. DATE OF OPERATION<br><b>2</b>  |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 21. AUTOPSY? (Yes or No)<br><b>yes</b>  |  |  |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>home</b>  |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br><b>5215 St. Charles Avenue 27-88</b>  |  | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)<br><b>10-17-69 ? a.m.</b>  |  |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | 22F. HOW DID INJURY OCCUR?<br><b>Pulled plastic bag over head and questionably ingested Nytol</b>  |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |  |  |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>Deputy Chief Medical Examiner <b>10/19/69</b> |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 24B. DATE<br><b>OCT. 22, 1969</b>  |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>DRUID RIDGE CEMETERY</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>PIKESVILLE 8, MD.</b>  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 28 1969</b>   |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Barber, M.D.</b>  |  |
| 25C. FUNERAL DIRECTOR<br><b>Frank A. Newell, Pikesville 8, Md.</b>  |  | ADDRESS  |  |

VS177 signed bu Dr.Spitz

FUNERAL DIRECTOR: IMPORTANT

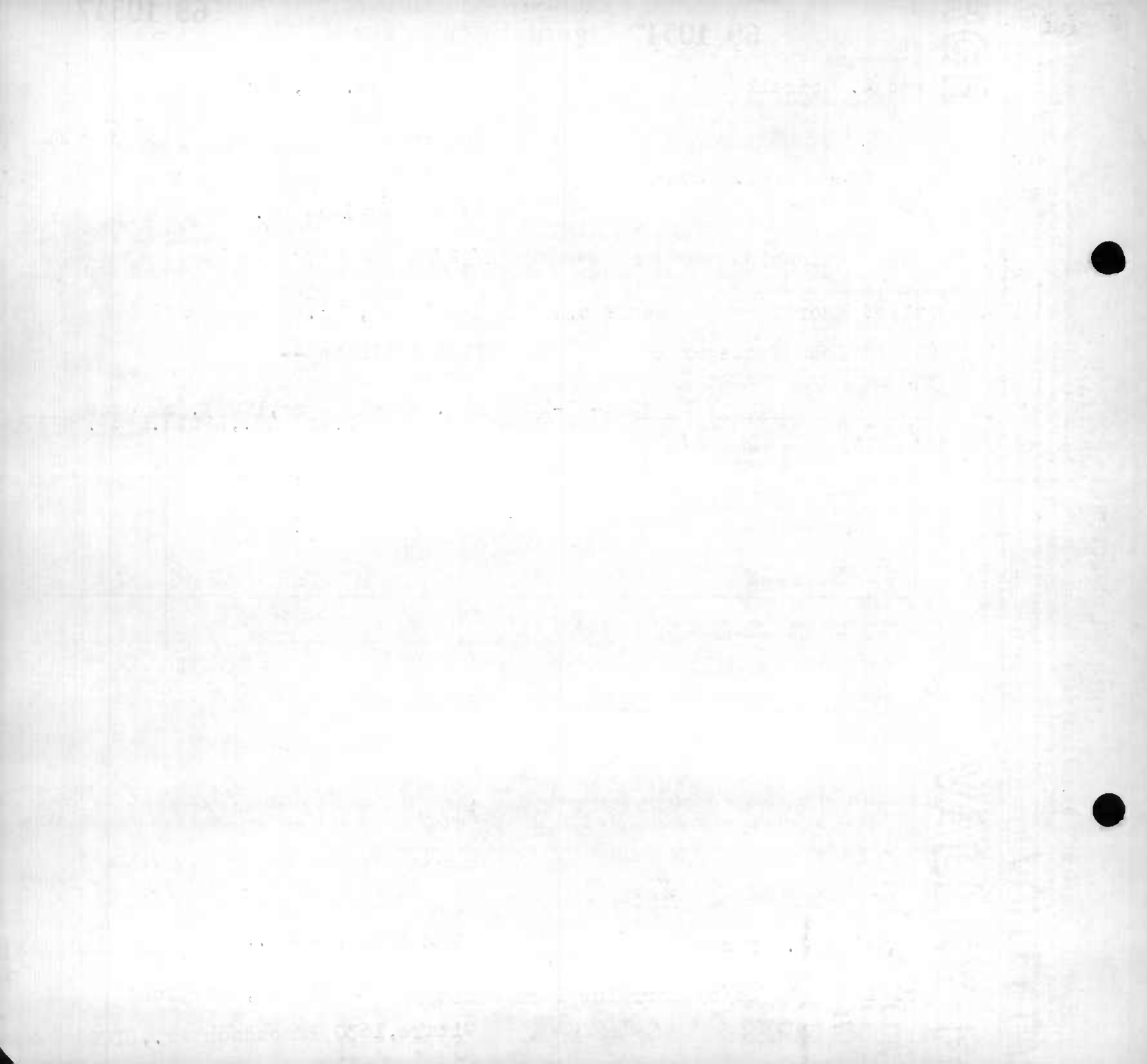
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-6401

# 69 10547 CERTIFICATE OF DEATH

REG. NO. 69 10547

|   |                             |   |                                    |  |   |  |  |
|---|-----------------------------|---|------------------------------------|--|---|--|--|
| BIRTH NO.   |                             | 1. NAME OF DECEASED<br>(Type or Print)<br><b>Irma A. Gorrell</b>  |                                    | 2. DATE AND HOUR OF DEATH<br><b>Oct. 26, 1969</b>  |   | M.   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>90 Hood Nursing Home</b><br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |                             |   |                                    | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>2864</b><br>C. CITY OR TOWN <b>Baltimore</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>4613 Manordene Rd.</b> |   |  |  |
| 5. SEX<br><b>Female</b>   | 6. RACE<br><b>Caucasion</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>3/14/91</b> | 9. AGE (In years last birthday)<br><b>78</b>   | If Under 1 Yr. Months Days<br>If Under 24 Hrs. Hours Min. |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Secretary</b>   |                             | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Secretary</b>   |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                           |  |
| 13. FATHER'S NAME<br><b>(late) John Applegarth</b>  |                             |   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>(late) Millie --</b>  |   |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |                             | 16. SOCIAL SECURITY NO.<br><b>212-01-1080</b>   |                                    | 17. INFORMANT<br><b>Mrs. Mabel Gwynn, 100 N. Hammonds Ferry Rd., Linth. Heights</b>  |   |  |  |
| 18. <b>172.9 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br><b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Dehydration - Malnutrition</b><br><b>(B) Intestinal Obstruction</b><br><b>(C) Diffuse melanotic sarcoma</b> |                             |   |                                    | CAUSE OF DEATH<br>GREATEST INTERVAL BETWEEN ONSET AND DEATH  |   |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |                             |   |                                    |  |   |  |  |
| 19A. DATE OF OPERATION<br><b>0</b>  |                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                    | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>   |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)   |                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |   |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                             | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                                    | 21F. HOW DID INJURY OCCUR?   |   |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Sept 1969</b> to <b>26 Oct 1969</b> , that (I) (we) last saw the deceased alive on <b>26 Oct 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                             |   |                                    |  |   |  |  |
| 23A. SIGNATURE<br><b>William J. Bryson</b>  |                             |   |                                    | 23B. DATE SIGNED<br><b>27 Oct 69</b>   |   | 23C. PHYSICIAN'S NAME (Type)<br><b>William J. Bryson</b>             |  |
| 23D. ADDRESS<br><b>4605 Edmondson Ave.,</b>   |                             | 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                    |  |   |  |  |
| 24B. DATE<br><b>10/28/69</b>  |                             | 24C. NAME of CEMETERY or CREMATORY<br><b>Lorraine Park Cemetery</b>   |                                    | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>  |   |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 28 1969</b>   |                             | 25B. NAME OF REGISTRAR<br><b>W. E. Faber, M.D.</b>  |                                    | 25C. FUNERAL DIRECTOR<br><b>Witzke, 1630 Edmondson Av., 21228</b>  |   |  |  |





FUNERAL DIRECTOR: IMPORTANT

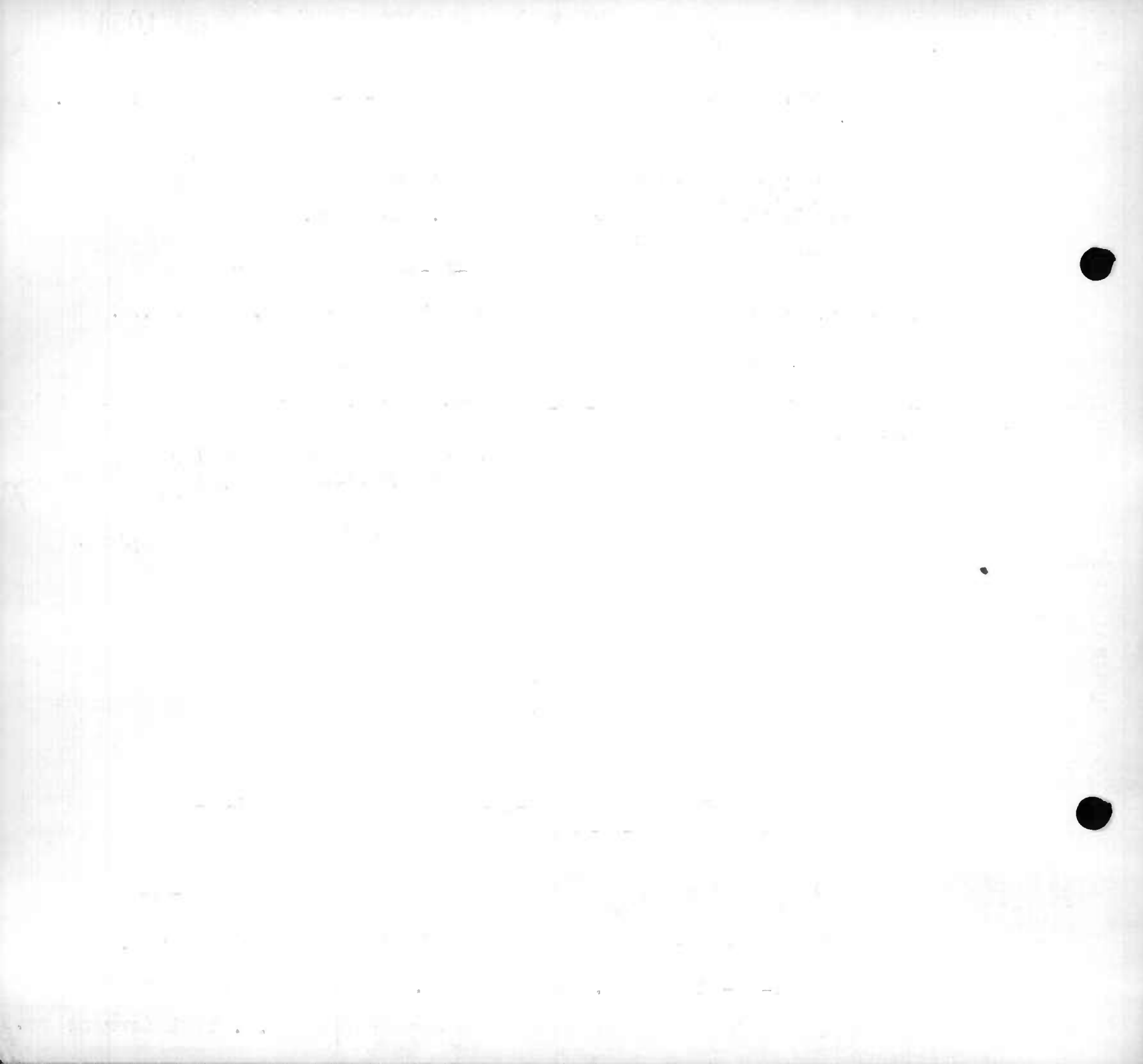
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |  |         |  |   |  |                  |  |                                 |  |  |  |                              |  |  |
|--|--|---------|--|---|--|------------------|--|---------------------------------|--|--|--|------------------------------|--|--|
| 69 10548   |  |         |  |   | CERTIFICATE OF DEATH   |                  |  |                                 |  |  |  |                              |  |  |
| REG. NO. 69 10548  |  |         |  |   |  |                  |  |                                 |  |  |  |                              |  |  |
| BIRTH NO.  |  |         |  |   | 1. NAME OF DECEASED<br>(Type or Print)   |                  |  |                                 |  | 2. DATE AND HOUR OF DEATH  |  |                              |  |  |
|  |  |         |  |   | WILLIAM F. FRISBY  |                  |  |                                 |  | October 25, 1969   |  |                              |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |         |  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)    |                  |  |                                 |  |  |  |                              |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |  |         |  |   | A. STATE   |                  |  |                                 |  | B. COUNTY  |  |                              |  |  |
|  |  |         |  |   | MARYLAND   |                  |  |                                 |  | Baltimore 53-00  |  |                              |  |  |
| 31 City Hospital   |  |         |  |   | C. CITY OR TOWN  |                  |  |                                 |  | D. INSIDE CITY LIMITS?   |  |                              |  |  |
|  |  |         |  |   | Balto., Co.  |                  |  |                                 |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |  |                              |  |  |
|  |  |         |  |   | E. STREET AND NUMBER   |                  |  |                                 |  |  |  |                              |  |  |
|  |  |         |  |   | 824 J Street   |                  |  |                                 |  |  |  |                              |  |  |
| 5. SEX   |  | 6. RACE |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  | 8. DATE OF BIRTH |  | 9. AGE (In years lost birthday) |  | 10. Under 1 Yr. Months Days  |  | 11. Under 24 Hrs. Hours Min. |  |  |
| Male   |  | Negro   |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |  | 8-12-20          |  | 49                              |  |  |  |                              |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |         |  |   | 10B. KIND OF BUSINESS OR INDUSTRY  |                  |  |                                 |  | 11. BIRTHPLACE (State or foreign country)                                |  |                              |  |  |
| Laborer  |  |         |  |   | Beth-Steel   |                  |  |                                 |  | Baltimore, Maryland  |  |                              |  |  |
| 12. CITIZEN OF WHAT COUNTRY?   |  |         |  |   | U.S.A.   |                  |  |                                 |  |  |  |                              |  |  |
| 13. FATHER'S NAME  |  |         |  |   | 14. MOTHER'S MAIDEN NAME   |                  |  |                                 |  |  |  |                              |  |  |
| James Frisby   |  |         |  |   | Francis Frisby   |                  |  |                                 |  |  |  |                              |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |  |         |  |   | 16. SOCIAL SECURITY NO.  |                  |  |                                 |  | 17. INFORMANT  |  |                              |  |  |
| Yes  |  |         |  |   | 10/31/42 11/17/45  |                  |  |                                 |  | 213-12-7674  |  |                              |  |  |
|  |  |         |  |   | Mrs. Naomi Frisby  |                  |  |                                 |  | 824 J Street   |  |                              |  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH   |  |         |  |   | CAUSE OF DEATH   |                  |  |                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |  |                              |  |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   |  |         |  |   | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                      |                  |  |                                 |  | Cardiac Failure  |  |                              |  |  |
|  |  |         |  |   | (B) DUE TO, OR AS A CONSEQUENCE OF:  |                  |  |                                 |  | Pneumonia  |  |                              |  |  |
|  |  |         |  |   | (C) DUE TO, OR AS A CONSEQUENCE OF:  |                  |  |                                 |  | Hypertensive Cardiac Vas. Dis.   |  |                              |  |  |
| ANTECEDENT CAUSES  |  |         |  |   |  |                  |  |                                 |  |  |  |                              |  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  |         |  |   |  |                  |  |                                 |  |  |  |                              |  |  |
| II   |  |         |  |   |  |                  |  |                                 |  |  |  |                              |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |         |  |   |  |                  |  |                                 |  |  |  |                              |  |  |
| 19A. DATE OF OPERATION   |  |         |  |   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                  |  |                                 |  | 20A. AUTOPSY? (Yes or No)  |  |                              |  |  |
|  |  |         |  |   |  |                  |  |                                 |  |  |  |                              |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  |         |  |   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |                  |  |                                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |                              |  |  |
|  |  |         |  |   |  |                  |  |                                 |  |  |  |                              |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  |         |  |   | 21E. INJURY OCCURRED   |                  |  |                                 |  | 21F. HOW DID INJURY OCCUR?   |  |                              |  |  |
|  |  |         |  |   | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |                  |  |                                 |  |  |  |                              |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from June 1950 to October 25, 1969.   |  |         |  |   |  |                  |  |                                 |  |  |  |                              |  |  |
| that (I) (we) last saw the deceased alive on October 22, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. |  |         |  |   |  |                  |  |                                 |  |  |  |                              |  |  |
| 23A. SIGNATURE   |  |         |  |   |  |                  |  |                                 |  | 23B. DATE SIGNED   |  |                              |  |  |
| William C. Wade, M.D.  |  |         |  |   |  |                  |  |                                 |  |  |  |                              |  |  |
| 23C. PHYSICIAN'S NAME (Type)   |  |         |  |   |  |                  |  |                                 |  | 23D. ADDRESS   |  |                              |  |  |
| William C. Wade, M.D.  |  |         |  |   |  |                  |  |                                 |  |  |  |                              |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |  |         |  |   | 24B. DATE  |                  |  |                                 |  | 24C. NAME OF CEMETERY or CREMATORY                                       |  |                              |  |  |
| Burial   |  |         |  |   | 10-31-69   |                  |  |                                 |  | Baltimore Nat'l Cem.   |  |                              |  |  |
| 24D. LOCATION (City, town, or county)  |  |         |  |   | (State)  |                  |  |                                 |  |  |  |                              |  |  |
| Baltimore,   |  |         |  |   | Maryland   |                  |  |                                 |  |  |  |                              |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.  |  |         |  |   | 25B. NAME OF REGISTRAR   |                  |  |                                 |  | 25C. FUNERAL DIRECTOR  |  |                              |  |  |
| OCT 28 1969  |  |         |  |   | Robert E. Taylor, R.D.   |                  |  |                                 |  | MORTON & DYETT F.H. 1701 Laurens St.                                     |  |                              |  |  |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |          |  |   |  |                   |  |
|--|--|----------|--|---|--|-------------------|--|
| BALTIMORE CITY HEALTH DEPARTMENT   |  | 69 10549 |  | CERTIFICATE OF DEATH  |  | REG. NO. 69 10549 |  |
| BIRTH NO.  |  |          |  | 1. NAME OF DECEASED<br>(Type or Print) <u>Groover, Ernest Ernest Groover</u>  |  |                   |  |
| 2. DATE AND HOUR OF DEATH<br><u>10-26-69</u> <u>8:00</u> <u>A.</u> <u>M.</u>   |  |          |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  |                   |  |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>Maryland</u> B. COUNTY <u>2002</u>  |  |          |  | FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>Provident Hospital</u><br><u>1514 Division Street</u><br><u>Baltimore, Maryland 21217</u>                     |  |                   |  |
| C. CITY OR TOWN <u>Baltimore</u>   |  |          |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |                   |  |
| E. STREET AND NUMBER<br><u>40 N. Gorman Ave.</u>   |  |          |  | 5. SEX <u>Male</u> 6. RACE <u>Negro</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                              |  |                   |  |
| 8. DATE OF BIRTH <u>8-12-00</u>  |  |          |  | 9. AGE (in years lost birthday) <u>69</u>   |  |                   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired Amer. Sugar</u>  |  |          |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  |                   |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Georgia, Bullock Co.</u>   |  |          |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>   |  |                   |  |
| 13. FATHER'S NAME<br><u>Tom Groover</u>  |  |          |  | 14. MOTHER'S MAIDEN NAME<br><u>Laura Groover</u>  |  |                   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>Yes</u> <u>4/24/19</u> <u>4/11/22</u>   |  |          |  | 16. SOCIAL SECURITY NO.<br><u>212-09-6141</u>   |  |                   |  |
| 17. INFORMANT<br><u>Mrs. Sabre Groover-Wife</u>  |  |          |  | ADDRESS<br><u>Same</u>  |  |                   |  |
| 18. <u>413B3 I</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br><u>II</u><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |  |          |  | CAUSE OF DEATH<br><u>ASHD P Cardiac Arrhythmia</u><br>(A) IMMEDIATE CAUSE <u>+ Pulchral Art. Embolus</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br><u>ASCVD P CHF</u><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) _____ |  |                   |  |
|  |  |          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>10-14 days</u><br><u>years</u>   |  |                   |  |
| 19A. DATE OF OPERATION<br><u>0</u>   |  |          |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |                   |  |
| 20A. AUTOPSY? (Yes or No)<br><u>No</u>   |  |          |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |                   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |  |          |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |                   |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |          |  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |  |                   |  |
| 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  |          |  | 21F. HOW DID INJURY OCCUR?  |  |                   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9-16-69</u> 19 to <u>10-26-69</u> 19 that (I) (we) last saw the deceased alive on <u>10-26-69</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |  |          |  |   |  |                   |  |
| 23A. SIGNATURE<br><u>Elijah Saunders</u>   |  |          |  | 23B. DATE SIGNED<br><u>10-27-69</u>   |  |                   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>Elijah Saunders</u>   |  |          |  | 23D. ADDRESS<br><u>1514 Division Street Baltimore, Md.</u>  |  |                   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  |          |  | 24B. DATE<br><u>10-28-69</u>  |  |                   |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><u>Balto. National Cem.</u>  |  |          |  | 24D. LOCATION (City, town, or county) (State)<br><u>Baltimore, Maryland</u>   |  |                   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>OCT 28 1969</u>  |  |          |  | 25B. NAME OF REGISTRAR<br><u>Robert E. Taylor, M.D.</u>   |  |                   |  |
| 25C. FUNERAL DIRECTOR<br><u>MORTON S. DAVIS</u>  |  |          |  | ADDRESS<br><u>1701 Laurens St.</u>  |  |                   |  |



1  
E-520

BALTIMORE CITY HEALTH DEPARTMENT

69 10550 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 10550

REG. NO.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

(Rosa) ROSE A. EANES

2. DATE OF DEATH

Known ☒ Estimated ☐

Month Day Year

10 24 69

Hour

3:15 a.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

00 421 Laurens St.

3. DATE PRONOUNCED DEAD

Month Day Year

Oct. 24, 1969

Hour

3:15 a.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

1402

6. SEX

Female

7. RACE

Negro

B. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

5-24-03

10. AGE (In years last birthday)

66

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

421 Laurens St.

11. BIRTHPLACE (State or foreign country)

Gloucester, Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Nick Robinson

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Mary E. Robinson

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No.

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

Mrs. Rosemary Hutton 421 Laurens St.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Isidore Mihalakis, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/24/69

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10-28-69

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cemetery

24D. LOCATION (City, town, or county)

Baltimore,

(State)

Maryland

25A. DATE REC'D BY HEALTH DEPT

OCT 28 1969

25B. NAME OF REGISTRAR

Isidore Mihalakis, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

MORTON & DYETT F.H. 1701 Laurens St.

03201 00

03 10550

WALLEY & CO. LTD.  
SHELLING CENTRE

WALLEY & CO. LTD.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |  |   |  | REG. NO. <b>69 10551</b>   |  |
|---|--|---|--|--|--|
| BIRTH NO. <b>69 10551</b>   |  | <b>CERTIFICATE OF DEATH</b>   |  |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Lee, Rosa</b>   |  | 2. DATE AND HOUR OF DEATH<br><b>10/23/69 4:10 p.m.</b>  |  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Lutheran Hospital</b>   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>1603</b>   |  |  |  |
| 5. SEX <b>F</b> 6. RACE <b>C</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                       |  | 8. DATE OF BIRTH <b>01-15-1891</b> 9. AGE (In years last birthday) <b>78</b>         |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>   |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Washington, D.C.</b>                 |  |
| 13. FATHER'S NAME<br><b>UNK.</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>UNK.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |  | 16. SOCIAL SECURITY NO.<br><b>217-30-25820</b>  |  | 17. INFORMANT<br><b>Mr. Donald Jackson</b>   |  |
| 18. <b>427.4 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br><b>RENAL FAILURE.</b><br><b>HYPOPROTEINEMIA.</b><br><b>ATRIAL FIBRILLATION.</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  | ADDRESS<br><b>Same</b>   |  |
| MEDICAL CERTIFICATION   |  | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>ARTERIO SCLEROSIS, Upper G.I. Bleeding</b> |  |  |  |
| 19A. DATE OF OPERATION<br><b>0 0</b>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>- 0</b>  |  | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><b>- 0</b>   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>0</b>  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>0</b> |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)<br><b>0</b>   |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> At Home <input checked="" type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?<br><b>0</b>   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10-11-1969</b> to <b>10-23-1969</b> , that (I) (we) lost saw the deceased alive on <b>10-23-1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |  |   |  |  |  |
| 23A. SIGNATURE<br><b>Rajinder P. Gandhi</b>   |  | 23B. DATE SIGNED<br><b>10-23-69</b>   |  | 23C. PHYSICIAN'S NAME (Type)<br><b>RAJINDER P. GANDHI</b>                            |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 24B. DATE<br><b>10/30/69</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cem.</b>                         |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>   |  | 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 28 1969</b>   |  | 25B. NAME OF REGISTRAR<br><b>W. E. Fisher, M.D.</b>                                  |  |
| 25C. FUNERAL DIRECTOR<br><b>Florston &amp; Dyett F.H.</b>   |  | 25D. ADDRESS<br><b>1701 Laurens St.</b>   |  |  |  |





5-5301

69 10552

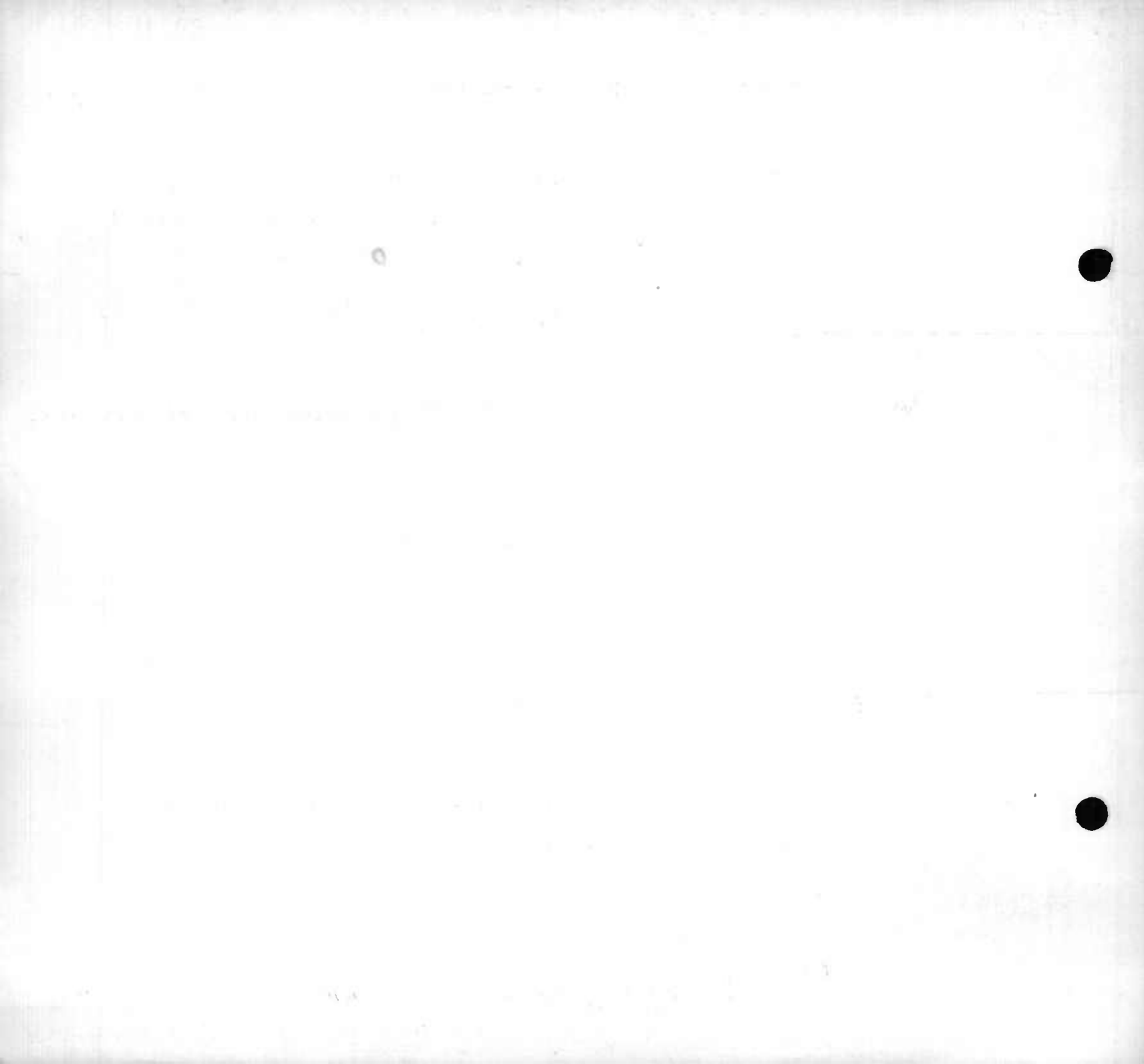
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 10552

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| BIRTH NO.  |  | 1. NAME OF DECEASED<br>(Type or Print) <i>Smith Martha</i>   |  | 2. DATE AND HOUR OF DEATH<br><i>October 25, 1969 2:00 P. M.</i>  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>MD.</i> B. COUNTY <i>-</i>  |  | C. CITY OR TOWN <i>BALTIMORE</i>   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>UNIVERSITY HOSPITAL OF MARYLAND</i><br><i>38</i>  |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 5. SEX <i>FEMALE</i>   |  | 6. RACE <i>NEGRO.</i>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 8. DATE OF BIRTH <i>6-26-07</i>  |  |
| 13. FATHER'S NAME<br><i>DAVE RICHARDSON</i>  |  | 14. MOTHER'S MAIDEN NAME<br><i>JANE CARTER</i>   |  | 9. AGE (In years last birthday) <i>62</i>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>NO.</i>   |  | 16. SOCIAL SECURITY NO.  |  | 11. BIRTHPLACE (State or foreign country)<br><i>BALTO., MARYLAND</i>   |  |
| 18. <i>174 X I</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <i>Renal failure.</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <i>Generalized Metastatic Ca. Breast (H)</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____ |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  |
| 17. INFORMANT<br><i>Mrs. Mary S. Parker</i>  |  | ADDRESS<br><i>4418 Norfolk Ave</i>   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| MEDICAL CERTIFICATION  |  |  |  |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |  |  |  |  |
| 19A. DATE OF OPERATION   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)<br><i>No</i>   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>10-14-1969</i> to <i>10-25-1969</i> that (I) (we) lost saw the deceased alive on <i>10-25-1969</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                       |  |  |  |  |  |
| 23A. SIGNATURE<br><i>Thanasophon</i>   |  | 23B. DATE SIGNED<br><i>Oct. 25, 69.</i>  |  | 23C. PHYSICIAN'S NAME (Type)<br><i>THANASOPHON</i>   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |  | 24B. DATE<br><i>10/28/69</i>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><i>Western Star Cem.</i>   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>OCT 28 1969</i>  |  | 25B. NAME OF REGISTRAR<br><i>Robert E. Fisher, M.D.</i>  |  | 25C. FUNERAL DIRECTOR<br><i>Mortuaries Dyett F.H.</i>  |  |
| 24D. LOCATION (City, town, or county)<br><i>Catonville, Maryland</i>   |  | 24E. ADDRESS<br><i>1701 Laurens St.</i>  |  |  |  |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 10553

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

69 10553

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN H. WILLIAMS

2. DATE AND HOUR OF DEATH

October 24, 1969

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

334 N. Hilton Street

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)  
A. STATE 8. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

334 N. Hilton Street

5. SEX

Male

6. RACE

Negro

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

2-10-97

9. AGE (in years  
last birthday)

72

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Steel Eastern Stainless

11. BIRTHPLACE (State or foreign country)

Lancaster, Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Isaac Williams

14. MOTHER'S MAIDEN NAME

Mary Jones

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL SECURITY NO.

214-12-2332

17. INFORMANT

Mrs. Georgia Knight

ADDRESS

1209 Presstman St.

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10-3-1969 to 10-14-1969, that (I) (we) last saw the deceased alive on 10-14-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S NAME (Type)

BARBU CALIN

DEGREE

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

10-25-69

23D. ADDRESS

831 Poplar Grove

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10-27-69

24C. NAME OF CEMETERY or CREMATORY

Carver Memorial Park

24D. LOCATION

Laurel,

(City, town, or county)

Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

OCT 28 1969

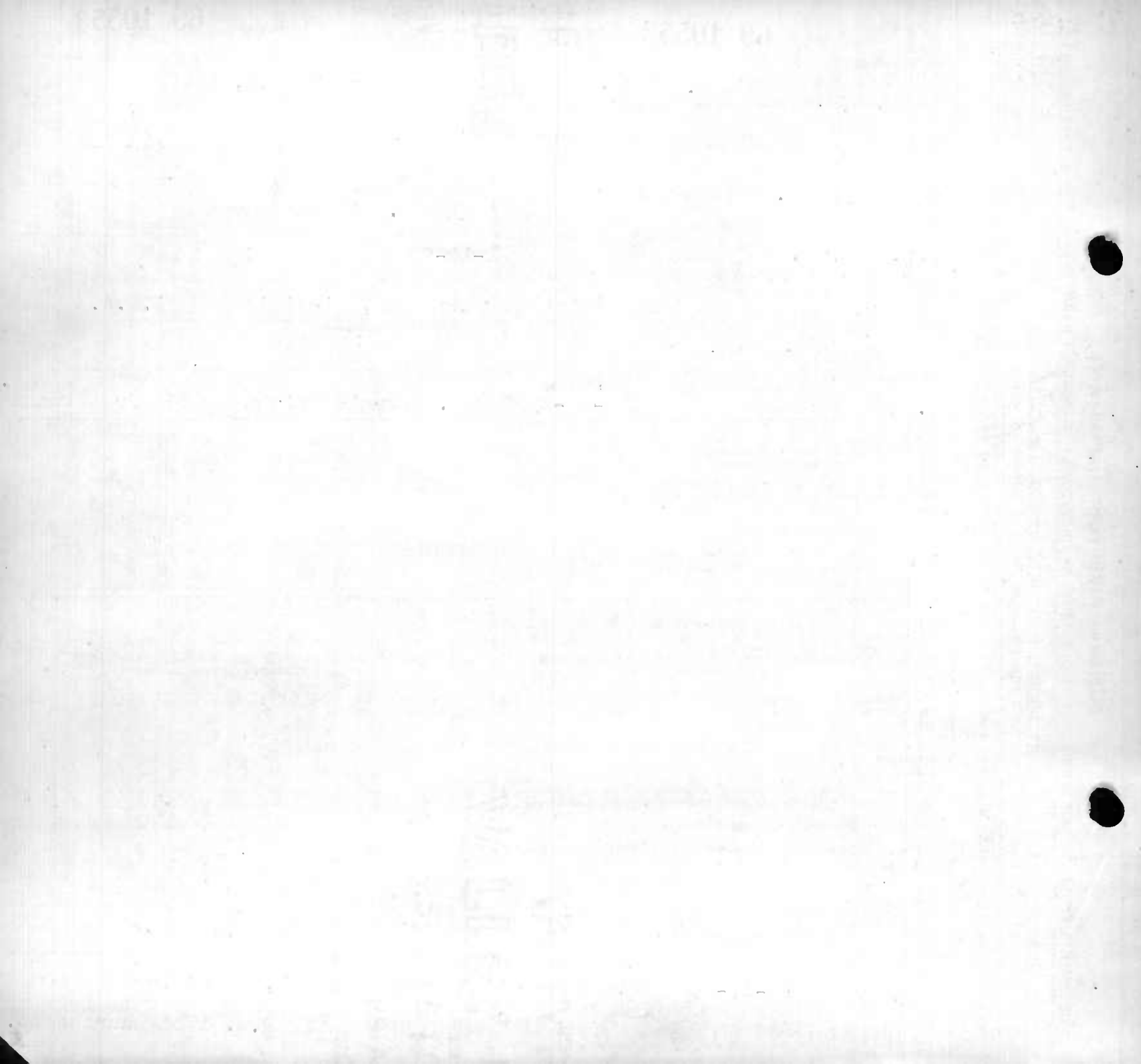
25B. NAME OF REGISTRAR

Robert E. Barber, M.D.

25C. FUNERAL DIRECTOR

MORTON & DYETT F.H. 1701 Laurens St.

ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                              |   |   |   |   |
|---|------------------------------|---|---|---|---|
| F-435 1   |                              | BALTIMORE CITY HEALTH DEPARTMENT  |   | REG. NO. <b>69 10554</b>  |   |
| BIRTH NO. <b>67-25665-69 10554</b>  |                              | CERTIFICATE OF DEATH  |   |   |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>LORRAINE FULTON</b>   |                              |   | 2. DATE AND HOUR OF DEATH<br><b>Oct. 23, 1969 11:00 PM</b>  |   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><b>UNIV. OF MARYLAND HOSPITAL</b><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>38</b>   |                              |   | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE CITY 2716</b> |   |   |
|   |                              |   | C. CITY OR TOWN<br><b>BALTIMORE</b>   |   | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|   |                              |   | E. STREET AND NUMBER<br><b>3104 VIRGINIA AVE</b>  |   |   |
| 5. SEX<br><b>F</b>  | 6. RACE<br><b>N</b>          | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12-26-67</b>   | 9. AGE (In years last birthday)<br><b>1</b>                                 | If Under 1 Yr. Months Days Hours<br><b>21 27</b>  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>INFANT</b>  |                              | 10B. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (State or foreign country)<br><b>MD. Balto.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |
| 13. FATHER'S NAME<br><b>WESLEY FULTON</b>   |                              |   | 14. MOTHER'S MAIDEN NAME<br><b>WILLIE LEE STARKS</b>  |   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO.</b>  |                              | 16. SOCIAL SECURITY NO.<br><b>—</b>   | 17. INFORMANT<br><b>MOTHER</b>  |   | ADDRESS<br><b>Same</b>  |
| 18. <b>246.91</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)<br><b>CONGESTIVE HEART FAILURE</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>CONGENITAL HEART DISEASE</b> |                              |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>MONGOLISM</b>  |                              |   |   |   |   |
| 19A. DATE OF OPERATION<br><b>0</b>  |                              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)<br><b>No</b>                                      |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |                              | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)    |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)   |                              | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |   | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Oct 23 19 69</b> to <b>Oct 23 19 69</b> , that (I) (we) last saw the deceased alive on <b>Oct. 23, 19 69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                              |   |   |   |   |
| 23A. SIGNATURE<br><b>Stanley Brull</b>  |                              |   | 23B. DATE SIGNED<br><b>Oct. 23, 1969</b>  |   |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>STANLEY BRULL</b>  |                              |   | 23D. ADDRESS<br><b>UNIV. OF MD. HOSP BALTO. MD</b>  |   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 24B. DATE<br><b>10-27-69</b> | 24C. NAME OF CEMETERY or CREMATORY<br><b>BALTO. NATIONAL</b>  |   | 24D. LOCATION (City, town, or county) (State)<br><b>BALTO, Md.</b>          |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 28 1969</b>   |                              | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>   |   | 25C. FUNERAL DIRECTOR ADDRESS<br><b>MORTON &amp; Dyer F.H. 1701 LAURENS</b> |   |

LOCKPORT TULCH

UNIT OF HARTLAND HOSPITAL

MD. 242 MOLE CITY

BART MOSE X

SICH VIRGINIA WEE

X 12-20-67 21 27

MD. U.S.A.

WILLIE LEE STARKS

MOTHER

CONSUMPTION HEART FAILURE

CONSUMPTION HEART FAILURE

MONGOLIAN

Oct 28, 1967

Stanley Bull

STANLEY BULL

UNIT OF MD. HOSP

DATO MD

X

Oct 28, 1967

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |                    |   |   | 69 10555  |  | REG. NO. 69 10555   |  |
|--|--------------------|---|---|---|--|---|--|
| BIRTH NO.  |                    |   |   | 1. NAME OF DECEASED<br>(Type or Print)  |  | 2. DATE AND HOUR OF DEATH   |  |
|  |                    |   |   | Oscar Mason   |  | 10-24-69  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                    |   |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><br>00 737 Lake Drive Apt. B1   |                    |   |   | A. STATE<br>Md.   |  | B. COUNTY   |  |
|  |                    |   |   | C. CITY OR TOWN<br>Balto.   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| E. STREET AND NUMBER<br>737 Lake Drive Apt. B1   |                    |   |   |   |  |   |  |
| 5. SEX<br>Male   | 6. RACE<br>Negroid | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>1-15-89                 | 9. AGE (In years last birthday)<br>80   | If Under 1 Yr. Months: Days:                     | If Under 24 Hrs. Hours: Min.  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                    |   | 10B. KIND OF BUSINESS OR INDUSTRY           |   | 11. BIRTHPLACE (State or foreign country)<br>Va. |   | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A. |
| 13. FATHER'S NAME<br>William Mason   |                    |   | 14. MOTHER'S MAIDEN NAME<br>Luevina Goodman |   |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>yes  |                    |   | 16. SOCIAL SECURITY NO.                     |   | 17. INFORMANT<br>Lottie Wallace same daughter    |   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)<br><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>412.41<br>Arteriosclerotic Cardio-vascular Disease<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF: |                    |   | CAUSE OF DEATH                              |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>13 months                                     |  |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                    |   |   |   |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |                    |   |   |   |  |   |  |
| 19A. DATE OF OPERATION   |                    | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)  |                    | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |  |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                    | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |   | 21F. HOW DID INJURY OCCUR?  |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 10 1969 to Oct 27 1969, that (I) (we) last saw the deceased alive on Oct 27 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                    |   |   |   |  |   |  |
| 23A. SIGNATURE<br>Ralph W. Reckling MD   |                    |   |   | 23B. DATE SIGNED<br>10/27/69  |  | 23C. PHYSICIAN'S NAME (Type)  |  |
| 23D. ADDRESS<br>2930 Baker St  |                    |   |   |   |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |                    | 24B. DATE<br>10-29-69   |   | 24C. NAME of CEMETERY or CREMATORY<br>Balto. Nat'l. Cem.                              |  | 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Maryland                          |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>OCT 28 1969   |                    | 25B. NAME OF REGISTRAR<br>Ralph E. Bailey   |   | 25C. FUNERAL DIRECTOR<br>V.R. Bailey<br>Nelson Funeral Home 1348 Calhoun St           |  |   |  |

ALLY POLICE  
F. W. POLICE  
F. W. POLICE



69 10556

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 10556

BIRTH NO.

|  |                      |   |  |
|--|----------------------|---|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>MARGARET F. Webster Smith</b>   |                      | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> 10 23 69<br>Hour 10:45 P.M.              |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>39 Provident Hospital</b>   |                      | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br>Oct. 23 1969 10:45 P.M.   |  |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>1602</b>  |                      | C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                    |  |
| 6. SEX <b>Female</b>   | 7. RACE <b>Negro</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. DATE OF BIRTH<br><b>9-11-25</b>   |                      | 10. AGE (In years lost birthday) <b>44</b><br>If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>  |                      | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                      | 14B. KIND OF BUSINESS OR INDUSTRY<br><b>Tower Apts.</b>   |  |
| 15. MOTHER'S MAIDEN NAME<br><b>Laura Owens</b>   |                      | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>  |  |
| 17. SOCIAL SECURITY NO.<br><b>218146648</b>  |                      | 18. INFORMANT ADDRESS<br><b>Roxanne Bernert 2046 Bentalon St.</b>   |  |
| 19. <b>41221</b><br>CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>Hypertensive cardiovascular disease<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 20A. DATE OF OPERATION   |                      | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                      | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                      | 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |  |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                      | 22F. HOW DID INJURY OCCUR?  |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED<br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Isidore Mihalakis, M.D.</b><br>EXAMINER'S NAME (Type) |                      |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                      | 24B. DATE<br><b>10-28-69</b>  |  |
| 24C. NAME of CEMETERY or CREMATORY<br><b>New Cathedral Cemetery</b>  |                      | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 28 1969</b>  |                      | 25B. NAME OF REGISTRAR<br><b>W. Bailey</b>  |  |
| 25C. FUNERAL DIRECTOR<br><b>Kelson F.H.</b>  |                      | 25D. ADDRESS<br><b>1348 Calhoun Street</b>  |  |

1000

1000

1000



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                  |   |                             |  |                             |   |                              |
|---|------------------|---|-----------------------------|--|-----------------------------|---|------------------------------|
| R-216 1   |                  | 69 10557  |                             | BALTIMORE CITY HEALTH DEPARTMENT   |                             | REG. NO. 69 10557   |                              |
| BIRTH NO.   |                  |   |                             | CERTIFICATE OF DEATH   |                             |   |                              |
| 1. NAME OF DECEASED<br>(Type or Print) EDDIE L. ROSEBOROUGH   |                  |   |                             | 2. DATE AND HOUR OF DEATH<br>10/26/69 18.30 P.M.   |                             |   |                              |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>UNIVERSITY HOSPITAL   |                  |   |                             | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>A. STATE MARYLAND B. COUNTY BALTIMORE CITY |                             |   |                              |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>UNIVERSITY HOSPITAL  |                  |   |                             | C. CITY OR TOWN<br>BALTIMORE   |                             | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                              |
| E. STREET AND NUMBER<br>2559 W. LOMBARD ST. 2004  |                  |   |                             |  |                             |   |                              |
| 5. SEX<br>MALE  | 6. RACE<br>NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>2/10/22 | 9. AGE (in years last birthday)<br>47  | 10. Under 1 Yr. Months Days |   | 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>MACHINE OPERATOR   |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>PEPSI COLA CO.   |                             | 11. BIRTHPLACE (State or foreign country)<br>SOUTH CAROLINA  |                             | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |                              |
| 13. FATHER'S NAME<br>CEASAR ROSEBOROUGH   |                  |   |                             | 14. MOTHER'S MAIDEN NAME<br>Sylvia Woodard   |                             |   |                              |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No  |                  | 16. SOCIAL SECURITY NO.<br>25036 9340   |                             | 17. INFORMANT<br>ANNIE ROSEBROUGH  |                             | ADDRESS<br>- SAME   |                              |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>METASTATIC CARCINOMA<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,<br>UNKNOWN PRIMARY CARCINOMA<br>QUESTIONABLE PANCREATIC CA.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br>DUODENAL ULCER |                  |   |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |                             |   |                              |
| 19A. DATE OF OPERATION<br>10/26/69  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                             | 20A. AUTOPSY? (Yes or No)<br>No  |                             | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |                              |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                             | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)  |                             |   |                              |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                             | 21F. HOW DID INJURY OCCUR?   |                             |   |                              |
| 22. I certify that (I) (this hospital) attended the deceased from 10/16/69 to 10/26/69 that (I) (we) last saw the deceased alive on 10/26/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                  |   |                             |  |                             |   |                              |
| 23A. SIGNATURE<br>A. H. Doyle   |                  |   |                             | 23B. DATE SIGNED<br>10/26/69   |                             | 23C. PHYSICIAN'S NAME (Type)<br>DEGREE  |                              |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |                  | 24B. DATE<br>10-30-69   |                             | 24C. NAME OF CEMETERY OR CREMATORY<br>Garden of Eternal Hope   |                             | 24D. LOCATION (City, town, or county) (State)<br>CARROLL COUNTY Md.                           |                              |
| 25A. DATE REC'D BY HEALTH DEPT.<br>OCT 28 1969  |                  | 25B. NAME OF REGISTRAR<br>Robert E. Fisher, M.D.  |                             | 25C. FUNERAL DIRECTOR<br>V. R. BAILEY  |                             | ADDRESS<br>1348 N. Calhoun St.  |                              |



P-4512

BALTIMORE CITY HEALTH DEPARTMENT

69 10558

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 10558

BIRTH NO. 69-72034

REG. NO.

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>ERNESTINE PAULING</b>  |  |   |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> 10 25 69 1:40 p.m.                                   |  |   |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Provident Hospital D.O.A.</b>   |  |   |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br>Oct. 25, 1969 1:40 p.m.  |  |   |  |
| 6. SEX<br><b>Female</b>   |  |   |  | 7. RACE<br><b>Negro</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. DATE OF BIRTH<br><b>7-8-69</b>   |  |   |  | 10. AGE (In years last birthday)<br><b>3</b>   |  | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>1302</b>                  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | C. CITY OR TOWN<br><b>Balto.</b>  |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  |   |  | 14B. KIND OF BUSINESS OR INDUSTRY  |  | E. STREET AND NUMBER<br><b>809 Whitelock St.</b>  |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>  |  |   |  | 17. SOCIAL SECURITY NO.<br><b>NONE</b>   |  | 15. MOTHER'S MAIDEN NAME<br><b>GEORGIANNA WALTERS</b>   |  |
| 19. <b>795X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |  |   |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <b>Sudden death in infancy</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) _____<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) _____ |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| 20A. DATE OF OPERATION<br><b>2</b>  |  |   |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |   |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  |   |  |
| 22D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)  |  |   |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?  |  |
| 23.<br>I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  | 22F. HOW DID INJURY OCCUR?   |  |   |  |
| ACTUAL SIGNATURE<br><b>Isidore Mihalakis, M.D.</b>  |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>     |  |   |  |
| EXAMINER'S NAME (Type)  |  |   |  | DATE SIGNED<br><b>10/26/69</b>   |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 24B. DATE<br><b>10-29-69</b>                            |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Mt. Auburn Cem.</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>BALTO. Md.</b>  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 28 1969</b>   |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b> |  | 25C. FUNERAL DIRECTOR<br><b>KELSON F.H. 1348 N. CALHOUN ST.</b>  |  |   |  |

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WALTER J. ROBERTS

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WALTER J. ROBERTS

WALTER J. ROBERTS

R. 263  
R. 263

69 10559

BALTIMORE CITY HEALTH DEPARTMENT

69 10559

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

|  |  |  |  |
|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>BENNIE ( RICHARDSON ) RICHARD</b>   |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> 10 21 69<br>7:50 a. M.                                |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Provident Hosp.</b>   |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>Oct. 21, 1969 7:50 a. M.</b>  |  |
| 6. SEX<br><b>Male</b>  |  | 7. RACE<br><b>Negro</b>  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | C. CITY OR TOWN<br><b>Balto. Md.</b>   |  |
| 9. DATE OF BIRTH<br><b>10-27-1907</b>  |  | 10. AGE (In years lost birthday) <b>61</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Georgia</b>  |  | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 15. MOTHER'S MAIDEN NAME<br><b>Mary Ector</b>  |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  |  | 17. SOCIAL SECURITY NO.  |  |
| 18. INFORMANT<br><b>Elizabeth Hamm</b>   |  | ADDRESS<br><b>1505 Baker St.</b>   |  |
| 19. <b>345.9</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Epilepsy</b>  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 20A. DATE OF OPERATION   |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |
| 22F. HOW DID INJURY OCCUR?   |  | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?   |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |
| ACTUAL SIGNATURE<br><b>Isidore Mihalakis, M.D.</b>   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |  |
| EXAMINER'S NAME (Type)   |  | DATE SIGNED<br><b>Oct. 21, 1969</b>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>10/25/69</b>   |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Mt. Calvary</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>AA Co. Md.</b>   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 28 1969</b>  |  | 25B. NAME OF REGISTRAR<br><b>Paul E. Faber, M.D.</b>   |  |
| 25C. FUNERAL DIRECTOR<br><b>Wilmington Phillips</b>  |  | ADDRESS<br><b>1727 N. Mount St.</b>  |  |

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WALLBURY HOLLIS

WALLBURY HOLLIS

WALLBURY HOLLIS



Approved and released by medical examiner  
K. T. Jung 10-27  
FUNERAL DIRECTOR: IMPORTANT

|  |                  |   |  |   |   |
|--|------------------|---|--|---|---|
| BIRTH NO. 69 10560   |                  | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. 69 10560                                     |   |
| 1. NAME OF DECEASED<br>(Type or Print) CHIPCHASE, FANNIE   |                  |   | 2. DATE AND HOUR OF DEATH<br>Oct. 27, 1969 10:30 A.M.  |   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>4+ UNION MEMORIAL HOSPITAL  |                  |   | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE MARYLAND USA. 1101<br>C. CITY OR TOWN BALTIMORE<br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER GUILFORD AND PRESTON |   |   |
| 5. SEX<br>F  | 6. RACE<br>WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>12-10-1881   | 9. AGE (in years last birthday)<br>87                 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>NONE  |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>NONE   |  | 11. BIRTHPLACE (State or foreign country)<br>MARYLAND |   |
| 12. CITIZEN OF WHAT COUNTRY<br>USA   |                  |   | 13. FATHER'S NAME<br>W. Edwin Chipchase  |   |   |
| 14. MOTHER'S MAIDEN NAME<br>Fannie Brown   |                  |   | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No   |   |   |
| 16. SOCIAL SECURITY NO.<br>228-44-9891   |                  |   | 17. INFORMANT<br>Mrs. F. Symington 103 Overhill Rd.  |   |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>E 887 X I<br>PULMONARY EMBOLISM<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(a) FRACTURE OF HIP<br>(b) DUE TO, OR AS A CONSEQUENCE OF:<br>(c) DUE TO, OR AS A CONSEQUENCE OF:<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>II<br>POST OPERATION OF JEWETT NAILING. RIGHT HIP<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>ABOUT ONE DAY  |                  |   |  |   |   |
| MEDICAL CERTIFICATION<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br>19A. DATE OF OPERATION<br>10-22-1969<br>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>FAIR<br>20A. AUTOPSY? (Yes or No)<br>No<br>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>Home<br>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>1101 Guilford & Preston Streets<br>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>10/21/69 3:45 pm<br>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/><br>21F. HOW DID INJURY OCCUR?<br>Subject fell to the floor<br>22. I certify that (I) (this hospital) attended the deceased from 10-21-69 to 10-27-69 that (I) (we) last saw the deceased alive on 10-27-69 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.<br>23A. SIGNATURE<br>Kasuke Tsiyimoto, M.D.<br>23B. DATE SIGNED<br>10-27-69<br>23C. PHYSICIAN'S NAME (Type)<br>Kasuke Tsiyimoto<br>23D. ADDRESS<br>Union Memorial Hospital<br>24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial<br>24B. DATE<br>10-29-69<br>24C. NAME OF CEMETERY OR CREMATORY<br>Green Mount Cemetery<br>24D. LOCATION (City, town, or county) (State)<br>Baltimore Md.<br>25A. DATE REC'D BY HEALTH DEPT.<br>OCT 28 1969<br>25B. NAME OF REGISTRAR<br>Robert E. Farber, R.D.<br>25C. FUNERAL DIRECTOR<br>H.W. Jenkins Sons Co. 4905 York Rd. Balto. Md. 21212 |                  |   |  |   |   |

address is 218 E. Preston St.

A

WATERBURY AND PRESTON  
X

X

WHITE

WAVE

550-44-1841

PULINARY EMBLISH

REPUTATION OF WESTMINSTER

NO

FAIR

12-25 1941

10-21-41

12-25

Westerly, N.Y.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 10561

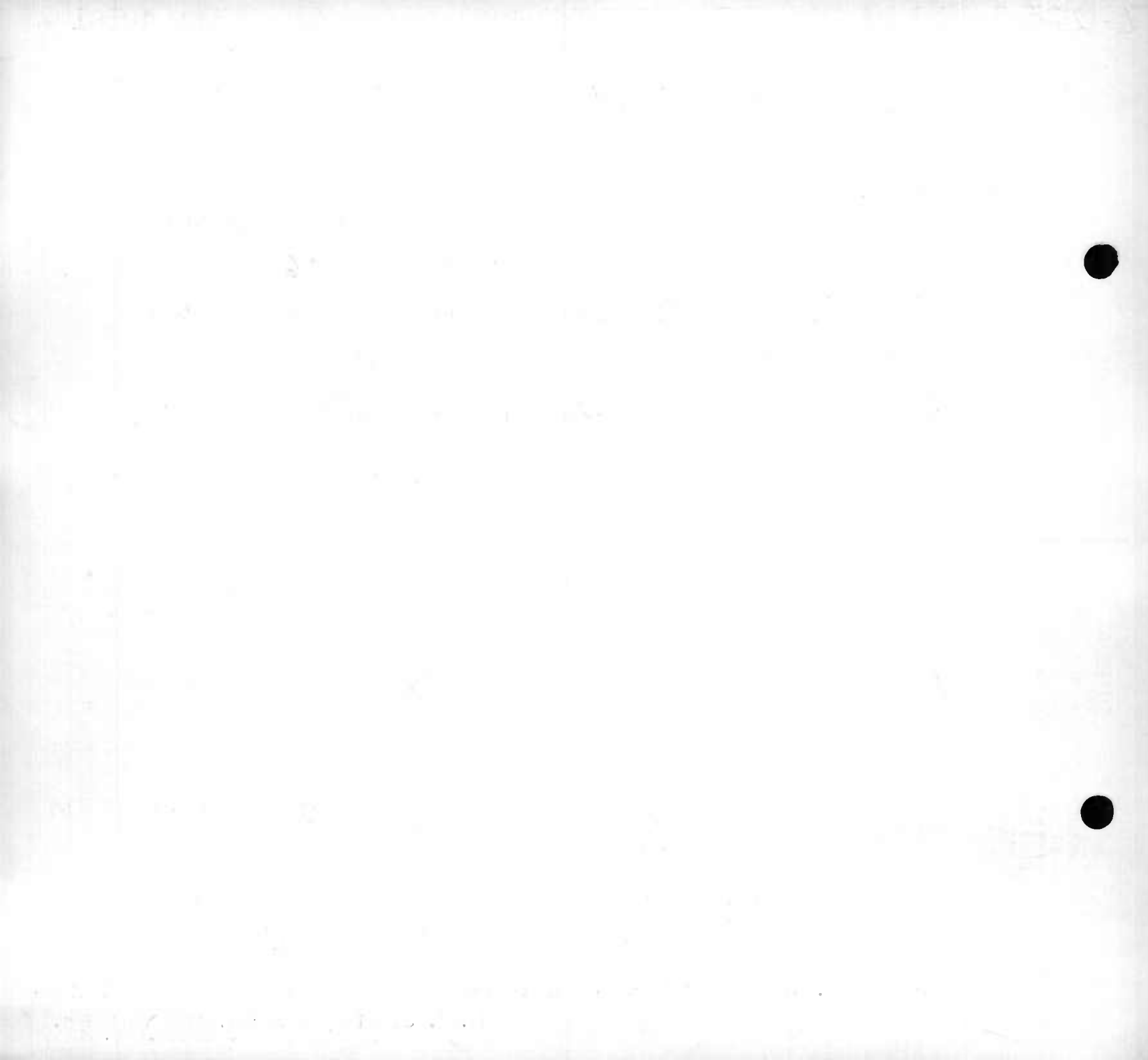
BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

69 10561

|   |  |  |   |
|---|--|--|---|
| BIRTH NO.   |  | 69 10561   |   |
| 1. NAME OF DECEASED<br>(Type or Print) <u>MRS. TERESA TALBOT LOGAN</u>  |  | 2. DATE AND HOUR OF DEATH<br><u>October 27, 1969</u> <u>11 20</u> <u>A</u> M.  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>University of Maryland Hospital</u><br><u>388</u>   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>Maryland</u><br>B. COUNTY <u>1307</u> |   |
| 5. SEX <u>F</u>   |  | 6. RACE <u>W</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home</u>   |   |
| 13. FATHER'S NAME<br><u>Cornelius Talbot</u>  |  | 14. MOTHER'S MAIDEN NAME<br><u>Mary Hickey</u>   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>   |  | 16. SOCIAL SECURITY NO.<br><u>380-22-0538</u>  |   |
| 17. INFORMANT<br><u>(Pt.'s chart) Miss Alice C. Logan</u>   |  | ADDRESS<br><u>1207 St. Regis Lane, Baltimore 21207</u>   |   |
| 18. <u>4/11/91</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><u>Acute Myocardial Infarction</u>  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>24 hrs.</u>   |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>II</u>   |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><u>Acute Myocardial Infarction</u>  |   |
|   |  | (B) DUE TO, OR AS A CONSEQUENCE OF:<br><u>Atherosclerotic Cardiovascular Disease</u>   |   |
|   |  | (C) <u>Symptomatic</u>   |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><u>II</u>   |  | <u>Chart not available</u>   |   |
| 19A. DATE OF OPERATION<br><u>0</u>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |
| 20A. AUTOPSY? (Yes or No)<br><u>No</u>  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |   |
| 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |  |  |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX.)  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                  |   |
| 21F. HOW DID INJURY OCCUR?  |  |  |   |
| 22. I certify that (I) (this hospital) attended the deceased from <u>October 11</u> 19 <u>69</u> to <u>October 27</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>October 27</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |   |
| 23A. SIGNATURE<br><u>Mark M. Applefeld, MD</u>  |  | 23B. DATE SIGNED<br><u>October 27, 1969</u>  |   |
| 23C. PHYSICIAN'S NAME (Type)<br><u>MARK M. APPLEFELD, MD</u>  |  | 23D. ADDRESS<br><u>Univ. of Maryland Hospital</u><br><u>Lombard &amp; Greene Streets Balto, Md.</u>  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial, Rem.</u>   |  | 24B. DATE<br><u>10-29-69</u>   |   |
| 24C. NAME OF CEMETERY or CREMATORY<br><u>Michigan Mem. Park</u>   |  | 24D. LOCATION (City, town, or county) (State)<br><u>Dearborn Michigan</u>  |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>OCT 28 1969</u>   |  | 25B. NAME OF REGISTRAR<br><u>Robert E. Talbot, R.D.</u>  |   |
| 25C. FUNERAL DIRECTOR<br><u>H. W. Wells Sons Co.</u>  |  | ADDRESS<br><u>4905 York Rd. Balto. Md. 21212</u>   |   |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT 69 10562 CERTIFICATE OF DEATH

REG. NO. 69 10562

|   |                     |  |                                      |  |   |
|---|---------------------|--|--------------------------------------|--|---|
| BIRTH NO.   |                     | 1. NAME OF DECEASED<br>(Type or Print) <b>Nell D. Kennady</b>  |                                      | 2. DATE AND HOUR OF DEATH<br><b>Oct. 25, 1969</b>   <b>8:45 A.</b> M.    |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Union Memorial Hospital</b><br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>DOA</b>  |                     | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Md.</b><br>B. COUNTY <b>2714</b><br>C. CITY OR TOWN <b>Baltimore</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>920 W. University Pkwy.</b> |                                      |  |   |
| 5. SEX<br><b>F</b>  | 6. RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>1-25-1894</b> | 9. AGE (In years last birthday)<br><b>75</b>                             | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Homemaker</b>   |                     | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |                                      | 11. BIRTHPLACE (State or foreign country)<br><b>Lebanon, Ky.</b>         |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                     | 13. FATHER'S NAME<br><b>Welborn Dearing</b>  |                                      | 14. MOTHER'S MAIDEN NAME<br><b>Margaret Wilkinson</b>                    |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                     | 16. SOCIAL SECURITY NO.  |                                      | 17. INFORMANT<br><b>Mrs. John A. Whittaker</b>                           |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><b>410.0 I Coronary occlusion</b><br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>HACVD</b><br><b>(B) anemia due to nephrosclerosis</b> |                     | CAUSE OF DEATH   |                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>a few hrs</b>         |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                     |  |                                      |  |   |
| 19A. DATE OF OPERATION  |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                      | 20A. AUTOPSY? (Yes or No)<br><b>no</b>                                   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                                      | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                                      | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Sept 29, 1969</b> to <b>Oct 25, 1969</b> , that (I) (we) last saw the deceased alive on <b>Oct 17, 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.   |                     |  |                                      |  |   |
| 23A. SIGNATURE<br><b>E. Hunter Wilson</b>   |                     | 23B. DATE SIGNED<br><b>10-27-69</b>  |                                      | 23C. PHYSICIAN'S NAME (Type)<br><b>Dr. E. Hunter Wilson</b>              |   |
| 23D. ADDRESS<br><b>Medical Arts Bldg.</b>   |                     | 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                      |  |   |
| 24B. DATE<br><b>10-28-69</b>  |                     | 24C. NAME OF CEMETERY or CREMATORY<br><b>Loudon Park Cemetery</b>  |                                      | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore Md.</b>    |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 28 1969</b>   |                     | 25B. NAME OF REGISTRAR<br><b>E. J. Baker, M.D.</b>   |                                      | 25C. FUNERAL DIRECTOR<br><b>H. W. Jenkins &amp; Sons Co.</b>             |   |
| 25D. ADDRESS<br><b>4905 York Rd. Balto. Md. 21212</b>   |                     |  |                                      |  |   |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 10563

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

69 10563

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Emma E. Ennis

2. DATE AND HOUR OF DEATH

Oct. 26, 1969

3:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)Broadview Apts.  
University Pkwy.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN  
Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

Broadview Apts. #807 University Pkwy.

5. SEX

6. RACE

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH

4-22-1892

9. AGE (In years  
last birthday)

76

If Under 1 Yr.  
Months DaysIf Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Homemaker

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Wilmington, Delaware

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

August Ebner

14. MOTHER'S MAIDEN NAME

Spahn

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, na or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

N. Y. ADDRESS

Mr. William W. Wilson 870 United Nations Plaza

18. 412.4 I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

Acute

+20 yrs

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

Parkinson's Disease

3 years

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (Notify medical examiner)

NO

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) ~~(this hospital)~~ attended the deceased from Aug. 30 1969 to Oct 26 1969,  
that (I) ~~(we)~~ lost saw the deceased alive on Oct - 2 19 69 and that in (my) ~~(our)~~ opinion death occurred on the date  
and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE

Conrad Acton

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☐

23B. DATE SIGNED

26 OCT 69

23C. PHYSICIAN'S  
NAME (Type)

Dr. Conrad Acton

DEGREE

23D. ADDRESS

2. E. Read St. 21202

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

10-29-1969

24C. NAME of CEMETERY or CREMATORY

Parkwood Cemetery

24D. LOCATION

(City, town, or county)

Parkville,

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

OCT 28 1969

25B. NAME OF REGISTRAR

R. E. Taylor, M.D.

25C. FUNERAL DIRECTOR

H. W. Jenkins Sons Co. 4905 York Rd.  
Balto., Md. 21212

ADDRESS

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 10564

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 10564

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Katherine E. Bierman

2. DATE AND HOUR OF DEATH

October 26, 1969 11 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Congress Hotel

306 W. Franklin St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md.

B. COUNTY

C. CITY OR TOWN Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

306 W. Franklin St.

5. SEX

F

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

5-6-1879

9. AGE (In years last birthday)

90

If Under 1 Yr. Months: Days: Hours: Min.

12. CITIZEN OF WHAT COUNTRY?

USA

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Registered Nurse

11. BIRTHPLACE (State or foreign country)

Balto. Md.

13. FATHER'S NAME

Carl C. Bierman

14. MOTHER'S MAIDEN NAME

Tina Neuman

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

217-30-4953

17. INFORMANT

ADDRESS

Mrs. Anna K. Windson 2928 Wyman Pkwy.

18.

4/10/9 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

White At Work ☐

Not White At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (the hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 24 Oct 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S NAME (Type)

Dr. Louis P. Hamburger, Jr.

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

10/27/69

23D. ADDRESS

1001 St. Paul St.

24A. BURIAL CREMATION, REMOVAL (Specify)

Cremation

24B. DATE

10-29-69

24C. NAME OF CEMETERY or CREMATORY

Green Mount Crematory

24D. LOCATION

Baltimore

(City, town, or county)

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

OCT 28 1969

25B. NAME OF REGISTRAR

Robert E. Taber, R.A.

25C. FUNERAL DIRECTOR

H. W. Jenkins Sons Co. 4905 York Rd. Balto. Md. 21212



1  
7-653

## BALTIMORE CITY HEALTH DEPARTMENT

69 10565 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 10565

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

James Triantas

2. DATE OF DEATH Known ☐ Month Day Year Hour  
Estimated ☐ M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

St. Agnes Hospital (DOA)

3. DATE PRONOUNCED DEAD Month Day Year Hour  
10 26 69 4:50 P.M.5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE M Maryland B. COUNTY 904

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

June 10, 1915

10. AGE (In years lost birthday)

54

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

2913 Greenmount Avenue

11. BIRTHPLACE (State or foreign country)

Pontiac, Mich.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Jacob Triantas

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Proprietor

14B. KIND OF BUSINESS OR INDUSTRY

Restaurant

15. MOTHER'S MAIDEN NAME

C. Ralos

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWII

17. SOCIAL SECURITY NO.

257-14-0933

18. INFORMANT

Mrs. Lois Rickmen, 830 Argonne Drive

ADDRESS

21218

19.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10-27-69

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10/29/69

24C. NAME of CEMETERY or CREMATORY

Baltimore National

24D. LOCATION (City, town, or county)

Baltimore

Md.

25A. DATE RECEIVED BY HEALTH DEPT.

OCT 28 1969

25B. NAME OF REGISTRAR

J. E. Fisher, M.D.

25C. FUNERAL DIRECTOR

H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto., Md. 21212

ADDRESS



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 10566

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

69 10566

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| BIRTH NO.   |  | 1. NAME OF DECEASED<br>(Type or Print) <b>Lee<br/>ELESTER WILSON</b>                                   |  | 2. DATE AND HOUR OF DEATH<br><b>10/24/1969</b> <b>530</b> P.M.  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>33 THE JOHNS HOPKINS HOSPITAL</b>   |  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>2636</b> |   |  |
| 5. SEX<br><b>MALE</b>   |  | 6. RACE<br><b>NEGRO</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH<br><b>12/12/39</b>   |  | 9. AGE (In years last birthday)<br><b>29</b>   |  | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Cook</b>  |  |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Public</b>   |   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Greenville, N.C.</b>  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |  |
| 13. FATHER'S NAME<br><b>JESSE JAMES Wilson</b>  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>LOUELLA GOULET</b>  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |  |  | 16. SOCIAL SECURITY NO.<br><b>237-52-0029</b>  |   |  |
| 17. INFORMANT<br><b>Mrs. Katie Wilson</b>   |  |  | ADDRESS<br><b>1305 Stromeier Way</b>   |   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>303.2 I</b><br><b>PANCREATITIS</b><br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>CHRONIC ALCOHOLISM</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 WEEK</b><br><b>10 YEARS</b>   |  |  |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |  |  |  |   |  |
| 19A. DATE OF OPERATION<br><b>2</b>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)<br><b>YES</b>   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>10/22</b> 19 <b>69</b> to <b>10/24</b> 19 <b>69</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>10/24</b> 19 <b>69</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (did not) view the body after death. |  |  |  |   |  |
| 23A. SIGNATURE<br><b>Karl J. Kramer, M.D.</b>   |  |  |  | 23B. DATE SIGNED<br><b>10/24/69</b>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>KARL J. KRAMER M.D.</b>  |  |  |  | 23D. ADDRESS<br><b>THE JOHNS HOPKINS HOSPITAL</b>   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>10-28-69</b>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Mt. Calvary Cemetery Anne Arundel Co., Md.</b>   |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>  |  | 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 28 1969</b>  |  |   |  |
| 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>   |  | 25C. FUNERAL DIRECTOR<br><b>Randolph J. Collick</b>  |  |   |  |
| 25D. ADDRESS<br><b>2431 E. Oliver St.</b>   |  |  |  |   |  |

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69 10567

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 69 10567

|   |                       |  |  |  |                                       |
|---|-----------------------|--|--|--|---------------------------------------|
| BIRTH NO.   |                       | 1. NAME OF DECEASED<br>(Type or Print) Anna<br>Marguerite A. Stenger   |  | 2. DATE AND HOUR OF DEATH<br>10/23/69 4:30 P.M.  |                                       |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                       |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland, Baltimore Co. 53-00<br>B. COUNTY     |                                       |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>31<br>BALTIMORE CITY HOSPITALS<br>4940 Eastern Avenue<br>Baltimore, Maryland 21224  |                       | C. CITY OR TOWN  |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                       |
| E. STREET AND NUMBER<br>7014 Germanhill Road 21222 005  |                       |  |  |  |                                       |
| 5. SEX<br>Female  | 6. RACE<br>White      | 7. MARRIED <input type="checkbox"/> NEVER MARRIED<br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 8. DATE OF BIRTH<br>8-18-14  | 9. AGE (In years last birthday)<br>55 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Ass't Mgr. Un. Trust   |                       | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br>Baltimore Maryland  |                                       |
| 13. FATHER'S NAME<br>Joseph A. Schaub   |                       | 14. MOTHER'S MAIDEN NAME<br>Anna Busch   |  |  |                                       |
| 15. Was Deceased Ever in U. S. Armed Forces?<br>(Yes, no or unknown) (If yes, give war or dates of service)   |                       | 16. SOCIAL SECURITY NO.<br>218-01-6735   |  | 17. INFORMANT<br>4940 Eastern Avenue<br>BCH-Records Baltimore, Maryland 21224  |                                       |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease or complication which caused death.)<br>E-887 IX<br>Brain stem decomposed   |                       | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>Brain stem decomposed                                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>15 min   |                                       |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                       | (B) Generalized cerebral contusion<br>(C) Occipital skull fx   |  | 28 hr<br>28 hr   |                                       |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |                       | High blood pressure  |  | ~ 5 yrs.   |                                       |
| 19A. DATE OF OPERATION<br>10/22/69  |                       | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Possible teratoma  |  | 20A. AUTOPSY? (Yes or No)<br>Yes   |                                       |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                       | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>Union Trust Bank                       |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>at place of employment 2600 collapsed + fell to floor studying hard. |                                       |
| 21D. TIME OF INJURY (APPROX.)<br>Oct 22, 69 12:30 pm  |                       | 21E. INJURY OCCURRED<br>While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>               |  | 21F. HOW DID INJURY OCCUR?<br>Sudden collapse while opening door at bank.  |                                       |
| 22. I certify that (I) (this hospital) attended the deceased from 22 Oct 1969 to 23 Oct 1969, that (I) (we) last saw the deceased alive on 22 Oct 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                       |  |  |  |                                       |
| 23A. SIGNATURE<br>Lawrence J. Jelsma  |                       | 23B. DATE SIGNED<br>23 Oct 69  |  | 23C. PHYSICIAN'S NAME (Type)<br>Lawrence J. Jelsma MD.   |                                       |
| 23D. ADDRESS<br>4940 Eastern Avenue<br>BCH Baltimore, Maryland 21224  |                       |  |  |  |                                       |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Entombment  | 24B. DATE<br>10/27/69 | 24C. NAME OF CEMETERY or CREMATORY<br>Lorraine Park Mausoleum  |  | 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Md.  |                                       |
| 25A. DATE REC'D BY HEALTH DEPT.<br>OCT 28 1969  |                       | 25B. NAME OF REGISTRAR<br>Robert E. Taylor, M.D.   |  | 25C. FUNERAL DIRECTOR<br>Schimunek Funeral Home, Inc.<br>3331 Brehms Lane  |                                       |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.







# FUNERAL DIRECTOR: IMPORTANT

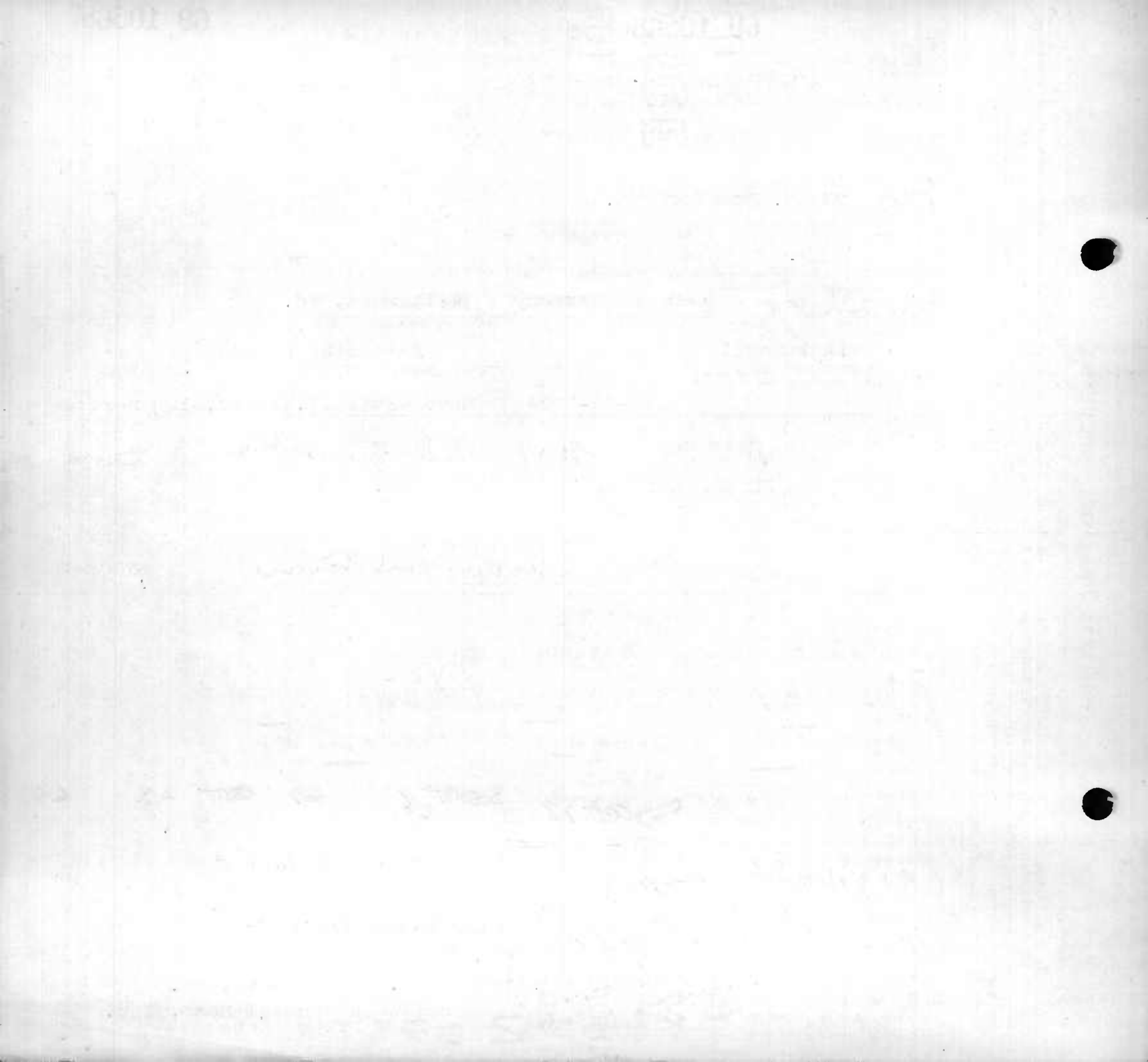
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 10568

## BALTIMORE CITY DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 69 10568

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| BIRTH NO.   |  | 1. NAME OF DECEASED<br>(Type or Print) <b>FRANCES J. KELLER</b>  |  | 2. DATE AND HOUR OF DEATH<br><b>10/23/69 5:40 AM</b>   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD</b> B. COUNTY <b>BALT. CITY</b> 21205 703        |  |
| FULL NAME OF HOSPITAL OR INSTITUTION  |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>00 921 N. Bradford St.</b>  |  | C. CITY OR TOWN <b>BALT.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                  |  |
| 5. SEX <b>F</b>   |  | 6. RACE <b>W</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>CLERK HOUSEWIFE</b>   |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Heck's Pharmacy</b>  |  | 8. DATE OF BIRTH<br><b>4/14/21</b>   |  |
| 13. FATHER'S NAME<br><b>Frank Kozel</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Josephine Brezina</b>   |  | 9. AGE (In years lost birthday)<br><b>48</b>   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO.<br><b>217-05-3924</b>  |  | 17. INFORMANT<br><b>Mary Westfall, sister, 6100 Bertram Av.</b>  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)<br><b>3820X</b>  |  | CAUSE OF DEATH<br><b>myocardial Infarction</b><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>chronic renal failure</b><br>(C) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>hours</b><br><br><b>years -</b>   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |  |  |  |  |
| 19A. DATE OF OPERATION<br><b>2</b>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)<br><b>Yes</b>  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)<br>—   |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>SEPT 1 1969</b> to <b>OCT 23 1969</b> , that (I) (we) last saw the deceased alive on <b>OCT 18 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |
| 23A. SIGNATURE<br><b>Robert Matzinger M.D.</b>  |  | 23B. DATE SIGNED<br><b>10-23-69</b>  |  | 23C. PHYSICIAN'S NAME (Type)<br><b>Robert Matzinger</b>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 24B. DATE<br><b>10/27/69</b>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Bohemian National Cem.</b>  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 28 1969</b>   |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>  |  | 25C. FUNERAL DIRECTOR<br><b>Schimmek Funeral Home, Inc.</b>  |  |
|   |  |  |  | 25D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>   |  |
|   |  |  |  | 25E. ADDRESS<br><b>8331 Brehms Lane</b>  |  |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-1521

69 10569

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 10569

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Harre H. Robbins

2. DATE AND HOUR OF DEATH

10/25/1969

9<sup>30</sup> A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

90 Harbor View Nursing Home  
1213 Light St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

Balto.

1307

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

3722 Tudor Arms Ave

5. SEX

Male

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH

11/29/1915

9. AGE (In years  
last birthday)

53

If Under 1 Yr.  
Months: Days:

If Under 24 Hrs.  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Salesman

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Harre Robbins

14. MOTHER'S MAIDEN NAME

Le Page Hough

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

212 09 1011

17. INFORMANT

ADDRESS

JANE ROBBINS 6427 Blenheim Rd.

18. I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

mos

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

21E. INJURY OCCURRED

While At  
Work ☐

Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (H) (this hospital) attended the deceased from 10/24 19 69 to 10/25 19 69,  
that (H) (we) last saw the deceased alive on 10/25 19 69 and that in (H) (our) opinion death occurred on the date  
and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S  
NAME (Type)

A.C. ALEVIZATOS, M.D.

OEGREE

Attending ☐

Med.  
Director ☒

Staff  
Phys. ☐

23B. DATE SIGNED

10/25/69

23D. ADDRESS

1209 5A Paul St. Balto, Md.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

10/27/69

24C. NAME of CEMETERY or CREMATORY

Mt. Olivet Cemetery

24D. LOCATION

Frederick Rd. Balto.

(City, town, or county)

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

OCT 28 1969

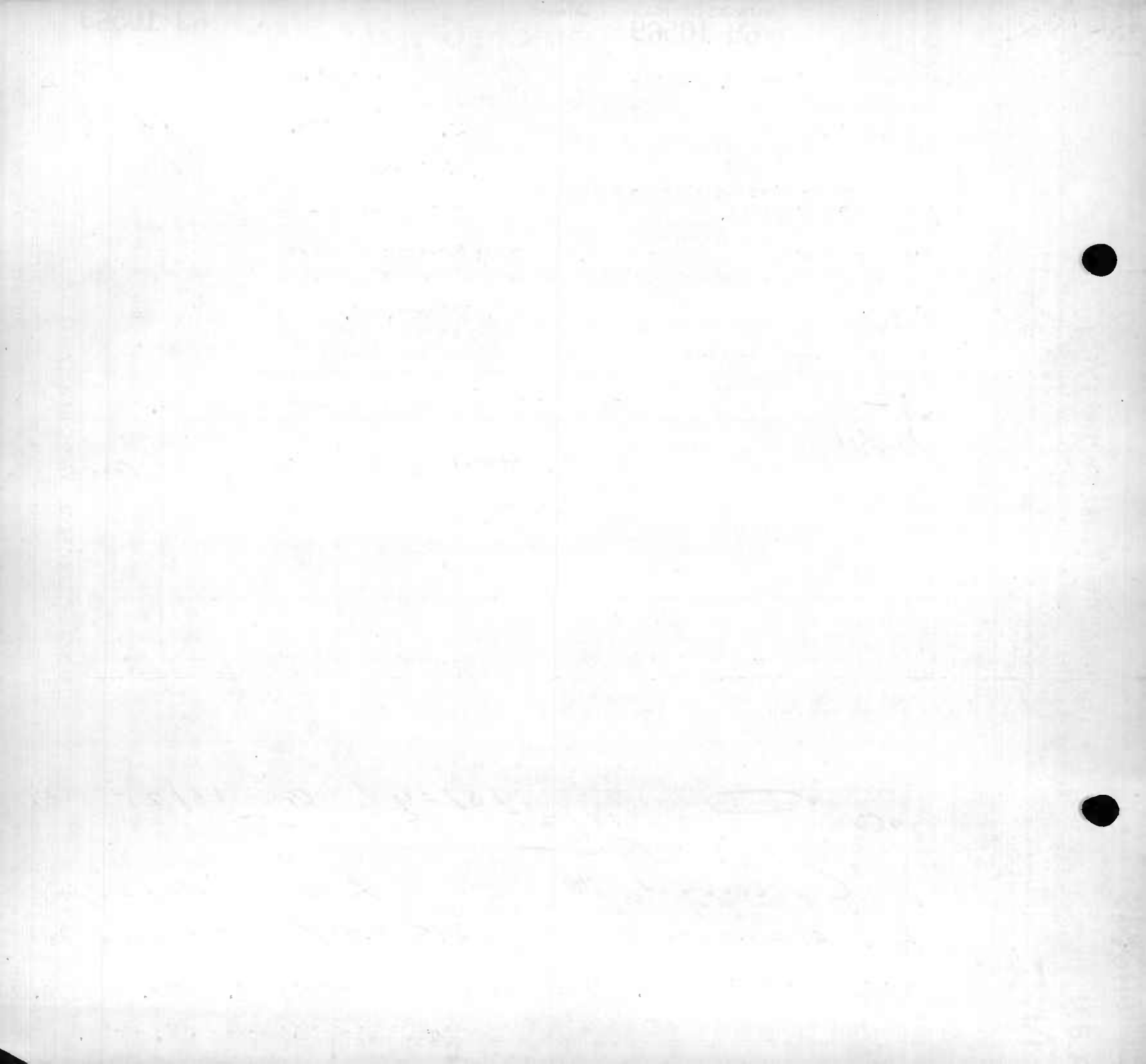
25B. NAME OF REGISTRAR

P. E. E. Fisher, M.D.

25C. FUNERAL DIRECTOR

Mitchell Wiedefeld Home 6500 York Rd.

ADDRESS



69 10570

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 10570

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

GRAFTON LEE BROWN

2. DATE AND HOUR OF DEATH

Oct. 21, 1969

2 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)UNION MEMORIAL HOSPITAL  
BALTIMORE MD4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)  
A. STATE

MD

B. COUNTY

2759

C. CITY OR TOWN

BALTIMORE MD

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

4416 MARBLE HALL RD

5. SEX

MALE

6. RACE

CAUCASIAN

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

7/11/96

9. AGE (In years  
lost birthday)

73

If Under 1 Yr.  
Months: Days:If Under 24 Hrs.  
Hours: Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Labor Dept.

10B. KIND OF BUSINESS OR INDUSTRY

Veterans Employment

11. BIRTHPLACE (State or foreign country)

MD Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

George Geo. Alexander Brown

14. MOTHER'S MAIDEN NAME

(1) Helen Smith

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

yes

W.W. I

16. SOCIAL  
SECURITY NO.

none

17. INFORMANT

ADDRESS

Mr. Jay P.W. Brown - 4416 Marble Hall Rd. 18

18.

410.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CARDIAC ARREST

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ACUTE MYOCARDIAL INFARCTION

(B)

DUE TO, OR AS A CONSEQUENCE OF:

ASCVD

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10/21 19 69 to 10/21 19 69,  
that (I) (we) last saw the deceased alive on 10/21 19 69 and that (in my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Ronald M. Legum M.D.

DEGREE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

10/21/69

23C. PHYSICIAN'S  
NAME (Type)

RONALD M. LEGUM M.D.

23D. ADDRESS

Union Memorial Hospital

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

10/24/69

24C. NAME OF CEMETERY or CREMATORY

Druid Ridge Cem

24D. LOCATION

(City, town, or county)

Baltimore

(State)

MD

25A. DATE REC'D BY HEALTH DEPT.

OCT 28 1969

25B. NAME OF REGISTRAR

Robert E. Taylor M.D.

25C. FUNERAL DIRECTOR

Mitchell Wiedefeld Home-6500 York Rd. 12

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CARROLL ARREST

ALL INFORMATION CONTAINED

HEREIN IS UNCLASSIFIED

DATE

MAILED

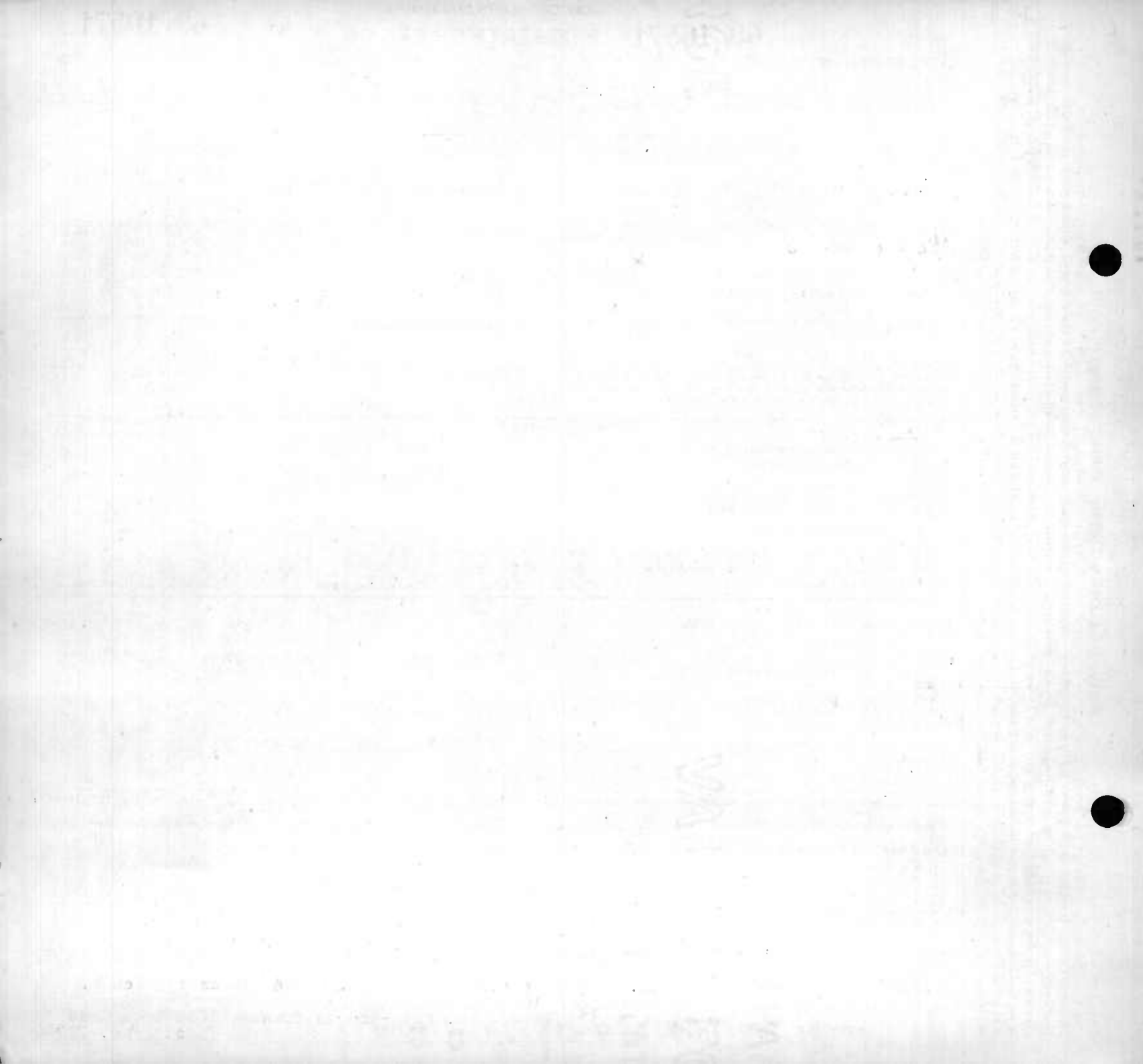
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## 69 10571 CERTIFICATE OF DEATH

REG. NO. **69 10571**

|  |                             |   |  |  |   |
|--|-----------------------------|---|--|--|---|
| BIRTH NO.  |                             | 1. NAME OF DECEASED<br>(Type or Print) <b>MARY LYDIA BARNES</b>   |  | 2. DATE AND HOUR OF DEATH<br><b>10/24/69 730 P.M.</b>                                    |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                             |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD</b> B. COUNTY <b>Baltimore</b> |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>JOHNS HOPKINS HOSPITAL</b>  |                             |   | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |  | 5. CITY OR TOWN<br><b>BALTIMORE</b>   |
|  |                             |   |  |  | 6. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|  |                             |   | E. STREET AND NUMBER<br><b>5625 FRANKFORT AVE</b>  |  |   |
| 5. SEX<br><b>female</b>  | 6. RACE<br><b>caucasian</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10/23/80</b>  | 9. AGE (In years last birthday)<br><b>88</b>   | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                             | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Penna.</b>                               |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |                             | 13. FATHER'S NAME<br><b>William Hill</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Ellen Handraham</b>                                       |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |                             | 16. SOCIAL SECURITY NO.<br><b>180-09-8113</b>   |  | 17. INFORMANT<br><b>Helen Barnes (daughter)</b>  |   |
| 18. <b>410.9 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Pulmonary embolus</b>   |                             | CAUSE OF DEATH  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b>                           |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                             | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Anterior myocardial infarction</b>   |  | 1 day  |   |
|  |                             | (B) <b>Diffuse arteriosclerosis</b>   |  | years  |   |
|  |                             | (C)   |  |  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                             |   |  |  |   |
| 19A. DATE OF OPERATION   |                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><b>No</b>   |   |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |                             |   |  |  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                 |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                             | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from <b>October 24 1969</b> to <b>October 24 1969</b> , that (I) <u>(we)</u> last saw the deceased alive on <b>October 24 1969</b> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death. |                             |   |  |  |   |
| 23A. SIGNATURE<br><b>Leroy M. Parker</b>   |                             |   |  | 23B. DATE SIGNED<br><b>10/24/69</b>  |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Leroy M. PARKER</b>   |                             |   |  | 23D. ADDRESS<br><b>609 North Broadway</b>  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                             | 24B. DATE<br><b>10-28-1969</b>  |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>St. Mary's Cemetery</b>                         |   |
| 24D. LOCATION<br><b>Mt. Carmel Township, Penna.</b>  |                             |   |  |  |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 28 1969</b>  |                             | 25B. NAME OF REGISTRAR<br><b>P. E. Taylor, Jr.</b>  |  | 25C. FUNERAL DIRECTOR<br><b>Wm. Cook-Brooks Towson, 1050 York Road Towson, Md. 21204</b> |   |





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |         |  |                  | REG. NO. 69 10572  |  |
|---|---------|--|------------------|--|--|
| 69 10572  |         |  |                  | CERTIFICATE OF DEATH   |  |
| BIRTH NO.   |         | 1. NAME OF DECEASED (Type or Print) FRANK E. MORRISON  |                  |  |  |
| 2. DATE AND HOUR OF DEATH   |         | October 26, 1969 6:35 P.M.   |                  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |         | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY |                  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |         | Maryland   |                  |  |  |
| 2617 Wilkens Avenue   |         | C. CITY OR TOWN D. INSIDE CITY LIMITS?   |                  |  |  |
| Baltimore, Maryland 21223   |         | Baltimore YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |                  |  |  |
| E. STREET AND NUMBER  |         | 2617 Wilkens Avenue  |                  |  |  |
| 5. SEX  | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                    | 8. DATE OF BIRTH | 9. AGE (In years last birthday)  | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| Male  | White   | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                       | 8-11-1897        | 72   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |         | 10B. KIND OF BUSINESS OR INDUSTRY  |                  | 11. BIRTHPLACE (State or foreign country)                                |  |
| Retired Machinist   |         | Federal Tin Co.  |                  | Maryland   |  |
| 13. FATHER'S NAME   |         | 14. MOTHER'S MAIDEN NAME   |                  | 12. CITIZEN OF WHAT COUNTRY?   |  |
| Richard L. Morrison   |         | Augusta Lichtenberg  |                  | U.S.A.   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |         | 16. SOCIAL SECURITY NO.  |                  | 17. INFORMANT ADDRESS  |  |
| Yes   |         | W W I 212-07-5361  |                  | 21223  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   |         | CAUSE OF DEATH   |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |  |
| 157.9 I   |         | Generalized carcinoma  |                  | 4 weeks  |  |
| ANTECEDENT CAUSES   |         | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  |                  |  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |         | (B) DUE TO, OR AS A CONSEQUENCE OF:  |                  | Ca of the pancreas 6 months  |  |
| (C) DUE TO, OR AS A CONSEQUENCE OF:   |         |  |                  |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |         |  |                  |  |  |
| 19A. DATE OF OPERATION  |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                  | 20A. AUTOPSY? (Yes or No)  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)   |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                 |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME OF INJURY (APPROX.)   |         | 21E. INJURY OCCURRED   |                  | 21F. HOW DID INJURY OCCUR?   |  |
|   |         | While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>                             |                  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 1957 to Oct 1969, that (I) (we) last saw the deceased alive on Oct 24 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |         |  |                  |  |  |
| 23A. SIGNATURE  |         |  |                  | 23B. DATE SIGNED   |  |
| Dr. Justin Kudirka  |         |  |                  | 10/27/69   |  |
| 23C. PHYSICIAN'S NAME (Type)  |         | 23D. ADDRESS   |                  |  |  |
| Dr. Justin Kudirka  |         | 2151 Wilkens Avenue, Baltimore, Maryland   |                  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |         | 24B. DATE  |                  | 24C. NAME of CEMETERY or CREMATORY                                       |  |
| Burial  |         | 10-30-1969   |                  | Loudon Park Cemetery   |  |
| 25A. DATE REC'D BY HEALTH DEPT.   |         | 25B. NAME OF REGISTRAR   |                  | 25C. FUNERAL DIRECTOR ADDRESS  |  |
| OCT 28 1969   |         | Howard H. Hubbard  |                  | 4107 Wilkens Avenue 21229  |  |

STOOL 20

STOOL 20



E-324

69 10573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

69 10573

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Isobel E. Etzler

2. DATE AND HOUR OF DEATH

October 24, 1969

6:35 AM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITALS

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland Frederick Co

60-00

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Unionville

YES ☐NO ☒

E. STREET AND NUMBER

NONE

5. SEX

6. RACE

Female

White

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

11-14-17

9. AGE (In years  
last birthday)

51

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

OWN HOME

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Benton Eury

14. MOTHER'S MAIDEN NAME

Bessie Appleby

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

216-07-6122

17. INFORMANT

4940 Eastern Avenue ADDRESS

BCH: Records Baltimore, Maryland 21224

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, oshtenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE Metastatic hypernephroma  
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY (Month) (Day) (Year) (Hour)  
(APPROX.)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from October 13 19 69 to October 24 19 69,  
that (I) (we) last saw the deceased alive on October 24 19 69 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Matthew Pollack M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

October 24, 1969

23C. PHYSICIAN'S  
NAME (Type)

Matthew Pollack, M.D.

DEGREE

23D. ADDRESS

4940 Eastern Avenue Baltimore, Maryland  
Baltimore City Hospitals 2122424A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

BURIAL

10/27/69

LINGANORE

UNIONVILLE

MD

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

OCT 28 1969

Robert E. Taylor, M.D.

S. D. Hartzler &amp; Sons Libertytown Md

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



0-165

## BALTIMORE CITY HEALTH DEPARTMENT

69 10574

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 10574

BIRTH NO.

REG. NO.

|   |  |   |  |
|---|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>MILTON O'BRIEN</b>   |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month Day Year Hour<br><b>10 25 69 11:30p M.</b>  |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>44 Union Memorial Hospital</b>   |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>Oct. 25, 1969 11:30 p.M.</b>   |  |
| 6. SEX<br><b>Male</b>   |  | 7. RACE<br><b>White</b>   |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | C. CITY OR TOWN<br><b>Balto.</b>  |  |
| 9. DATE OF BIRTH<br><b>Aug. 5, 1918</b>   |  | 10. AGE (In years lost birthday)<br><b>51</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>?</b>  |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Chauffeur.</b>  |  | 14B. KIND OF BUSINESS OR INDUSTRY<br><b>Trucking</b>  |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes. WWII</b>   |  | 17. SOCIAL SECURITY NO.<br><b>?</b>   |  |
| 18. INFORMANT<br><b>Ella L.O'Brien 4243 Elsa Terrace.</b>   |  | ADDRESS<br><b>4243 Elsa Terrace</b>   |  |
| 19. <b>412.2</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Hypertensive cardiovascular disease</b>  |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Hypertensive cardiovascular disease</b>  |  |
| 20. DATE OF OPERATION<br><b>2</b>   |  | 21. AUTOPSY? (Yes or No)<br><b>YES</b>  |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |
| 22D. TIME OF INJURY (Approx.)<br>(Month) (Day) (Year) (Hour)<br><b>22E. INJURY OCCURRED</b><br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |
| 22F. HOW DID INJURY OCCUR?  |  |   |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br><b>Isidore Mihalakis, M.D.</b>  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED<br><b>10/25, 1969</b> |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial.</b>  |  | 24B. DATE<br><b>Oct. 28, 1969</b>   |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Balto. Notional.</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>Balto.</b>  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 28 1969</b>   |  | 25B. NAME OF REGISTRAR<br><b>Paul E. Fahey, M.D.</b>  |  |
| 25C. FUNERAL DIRECTOR<br><b>Paul E. Chenoweth Jr.</b>   |  | ADDRESS<br><b>3615 Chestnut Ave.</b>  |  |

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WALKLEY

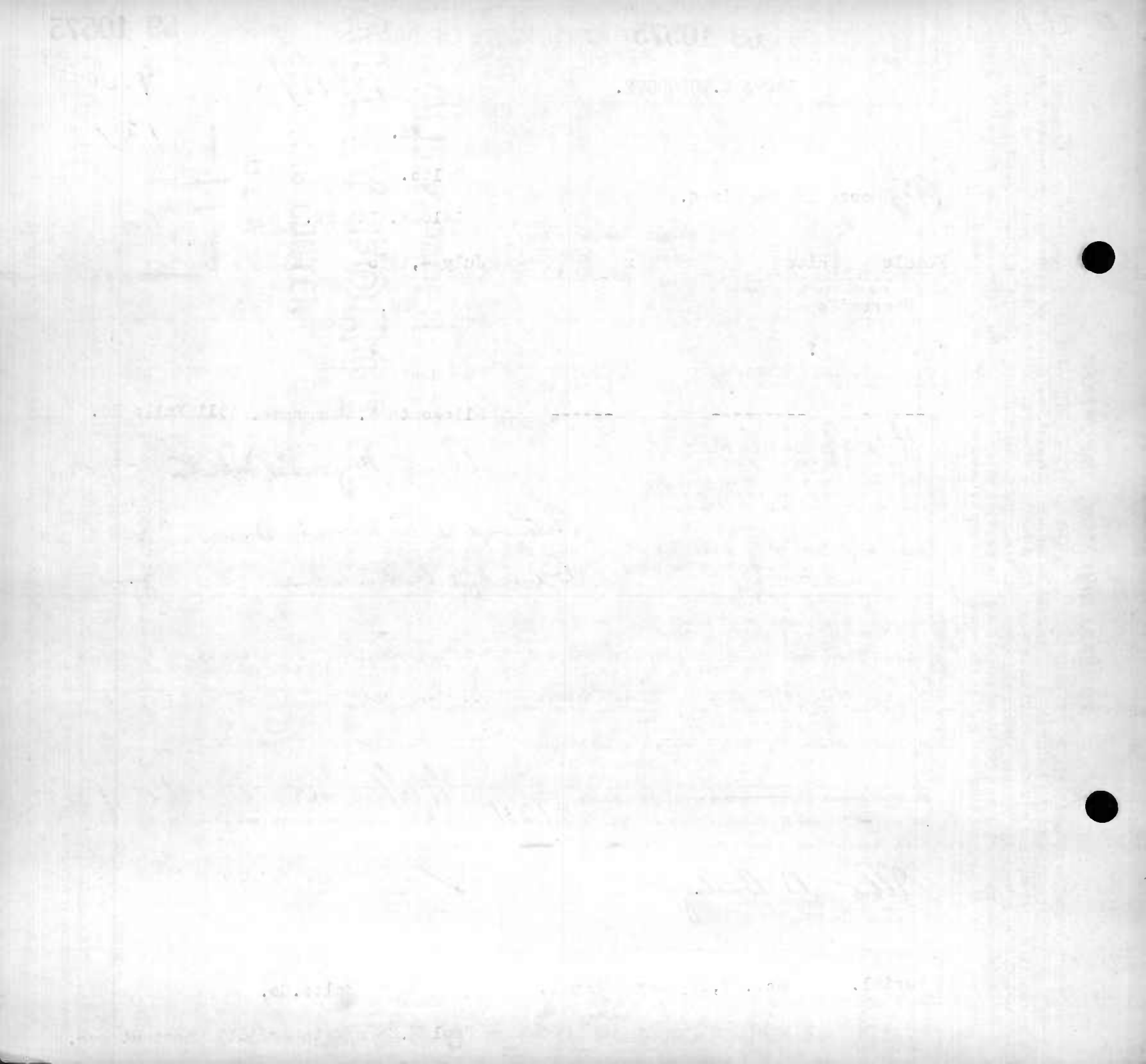
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |                      |   |                                      | REG. NO. <b>69 10575</b>                             |
|--|----------------------|---|--------------------------------------|--|
| BIRTH NO. <b>69 10575</b>  |                      | <b>CERTIFICATE OF DEATH</b>   |                                      |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>LAURA V. MUSGROVE.</b>   |                      | 2. DATE AND HOUR OF DEATH<br><b>10/25/69 4:30 PM</b>  |                                      |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>90 House IN The Pines.</b>   |                      | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b><br>B. COUNTY <b>Balto.</b><br>C. CITY OR TOWN <b>Balto.</b><br>D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>1416 W. 37th St.</b> |                                      |  |
| 5. SEX <b>Female</b>   | 6. RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <b>July 4, 1886</b> | 9. AGE (In years last birthday) <b>83</b>            |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                      | 10B. KIND OF BUSINESS OR INDUSTRY   |                                      | 11. BIRTHPLACE (State or foreign country) <b>Md.</b> |
| 12. CITIZEN OF WHAT COUNTRY?   |                      | 13. FATHER'S NAME <b>?</b>  |                                      |  |
| 14. MOTHER'S MAIDEN NAME <b>?</b>  |                      | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |                                      |  |
| 16. SOCIAL SECURITY NO.  |                      | 17. INFORMANT <b>Ellsworth B. Musgrove. 5911 Falls Rd.</b>  |                                      |  |
| 18. CAUSE OF DEATH<br>I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><br>19A. DATE OF OPERATION<br>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>19C. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br>19D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)<br>20A. AUTOPSY? (Yes or No)<br>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>21A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>21C. HOW DID INJURY OCCUR?<br>21D. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/><br>22. I certify that (I) (this hospital) attended the deceased from <b>9/23/69</b> to <b>10/25/69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.<br>23A. SIGNATURE <b>Ellsworth B. Musgrove</b><br>23B. DATE SIGNED<br>23C. PHYSICIAN'S NAME (Type)<br>23D. ADDRESS<br>24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial.</b><br>24B. DATE <b>Oct. 29, 69</b><br>24C. NAME OF CEMETERY or CREMATORY <b>Mays Chapel.</b><br>24D. LOCATION (City, town, or county) (State) <b>Balto. Co.</b><br>25A. DATE REC'D BY HEALTH DEPT. <b>OCT 28 1969</b><br>25B. NAME OF REGISTRAR <b>Robert E. Gable, M.D.</b><br>25C. FUNERAL DIRECTOR <b>Paul E. Chenoweth Jr 3615 Chestnut Ave.</b> |                      |   |                                      |  |





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 69 10576 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

69 10576

|   |  |  |  |  |   |
|---|--|--|--|--|---|
| BIRTH NO.   |  | 1. NAME OF DECEASED<br>(Type or Print)   |  | 2. DATE AND HOUR OF DEATH  |   |
|   |  | Annie P. Podeyn  |  | 10-20-1969 12:30 P.M.  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)      |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |  |  | A. STATE B. COUNTY   |  |   |
| 90 Could Nursing Home<br>Belair Road  |  |  | Md. 2734   |  |   |
| 5. SEX  |  |  | 6. RACE  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |
| female  |  |  | Cau.   |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 8. DATE OF BIRTH   |   |
| Housewife   |  | Housewife  |  | 3-3-1889   |   |
| 11. BIRTHPLACE (State or foreign country)   |  | 12. CITIZEN OF WHAT COUNTRY?   |  | 9. AGE (In years lost birthday)  |   |
| New York  |  | U.S.A.   |  | 80   |   |
| 13. FATHER'S NAME   |  |  | 14. MOTHER'S MAIDEN NAME   |  |   |
| Louis Weymuth   |  |  | Annie Gass   |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces?<br>(Yes, no or unknown) (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |   |
| No  |  | 218-32-0088  |  | Rev. George Blankner 5740 Belair Road 21266                              |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |
| I<br>412.3 I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |  |  | Instantaneous  |  |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>1. Coronary sclerosis               |  |   |
|   |  |  | (B) DUE TO, OR AS A CONSEQUENCE OF:<br>2. Generalized arteriosclerosis especially cerebral |  |   |
|   |  |  | 5-10 years   |  |   |
|   |  |  | 5-10 years   |  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |  |  |  |   |
| 19A. DATE OF OPERATION  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)  |   |
| 0   |  |  |  | No   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
|   |  |  |  |  |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |   |
|   |  |  |  |  |   |
| 22. I certify that (H) (this hospital) attended the deceased from 1960 to 10-20-69 and that (H) (we) lost saw the deceased alive on 7-23-69 and that in (my) (our) applan death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. (Did not) |  |  |  |  |   |
| 23A. SIGNATURE George Sawyer M.D. (M.D. M.P.)<br>G.W. PEARKE M.D. (M.D. M.P.)   |  |  |  | 23B. DATE SIGNED 10-21-69  |   |
| 23C. PHYSICIAN'S NAME (Type) GEORGE SAWYER M.D. C.W. PEARKE M.D.  |  |  |  | 23D. ADDRESS 4508 Hanford Road   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |  | 24B. DATE  |  | 24C. NAME OF CEMETERY OR CREMATORY                                       |   |
| Burial  |  | 10-22-1969   |  | Gardens of Faith Cemetery  |   |
| 25A. DATE REC'D BY HEALTH DEPT.   |  | 25B. NAME OF REGISTRAR   |  | 25C. FUNERAL DIRECTOR  |   |
|   |  |  |  | Passah Funeral Home 7401 Belair Road 21236                               |   |

6116 Dublin Rd. - address

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
**69 10577 CERTIFICATE OF DEATH**

REG. NO. **69 10577**

|  |                    |   |  |   |   |
|--|--------------------|---|--|---|---|
| BIRTH NO.  |                    | 1. NAME OF DECEASED<br>(Type or Print) <b>RUSSELL J. PARRIS</b>   |  | 2. DATE AND HOUR OF DEATH<br><b>10-20-69 3:00 P.M.</b>  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                    |   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>Harpers</b> |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>UNION MEMORIAL HOSPITAL</b>   |                    | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |  | C. CITY OR TOWN <b>CHURCHVILLE</b>  |   |
| D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                    | E. STREET AND NUMBER <b>Rt. 1 Box 157</b>   |  |   |   |
| 5. SEX <b>M</b>  | 6. RACE <b>Can</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>2-27-98</b>   | 9. AGE (In years lost birthday) <b>71</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Yard Master Ret.</b>   |                    | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Patapaco R. R.</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>GEORGIA</b>   |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                    | 13. FATHER'S NAME<br><b>LEONARD PARRIS</b>  |  |   |   |
| 14. MOTHER'S MAIDEN NAME<br><b>MARY ELLA BENTON</b>  |                    | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>UNKNOWN</b>                                  |  |   |   |
| 16. SOCIAL SECURITY NO.<br><b>705-10-9788</b>  |                    | 17. INFORMANT<br><b>ADMISSION HISTORY</b>   |  |   |   |
| 18. <b>441.21</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>ACUTE RENAL FAILURE</b><br><b>acute cardiac insufficiency</b>  |                    | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>ATHEROSCLEROSIS</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 d</b><br><b>20 years</b><br><b>(D.H.)</b>  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                    |   |  |   |   |
| 19A. DATE OF OPERATION<br><b>10-16-69</b>  |                    | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>ABDOMINAL ANEURYSM</b>   |  | 20A. AUTOPSY? (Yes or No)<br><b>YES</b>   |   |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>NO</b>  |                    | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><b>NO</b>  |  |   |   |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                    | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |  | 21D. TIME OF INJURY (APPROX.)   |   |
| 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                    | 21F. HOW DID INJURY OCCUR?  |  |   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10-16-1969</b> to <b>10-20-1969</b> , that (I) (we) last saw the deceased alive on <b>10-20-1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                    |   |  |   |   |
| 23A. SIGNATURE<br><b>J. Shaffer M.D.</b>   |                    | 23B. DATE SIGNED<br><b>10-20-69</b>   |  | 23C. PHYSICIAN'S NAME (Type)<br><b>Union Memorial Hosp</b>  |   |
| 23D. ADDRESS<br><b>Dorsey Maryland</b>   |                    | 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |   |   |
| 24B. DATE<br><b>10/23/69</b>   |                    | 24C. NAME of CEMETERY or CREMATORY<br><b>Meadow Ridge Mem.</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Dorsey Maryland</b>   |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 28 1969</b>  |                    | 25B. NAME OF REGISTRAR<br><b>Robert E. Faerber, M.D.</b>  |  | 25C. FUNERAL DIRECTOR<br><b>Lassahn Funeral Home 7401 Belair Road</b>   |   |

*and some  
suffered*

(H.C.)

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |   |  |
|---|--|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. <b>69 10578</b>  |  |
| I-220   |  | 69 10578  |  |
| BIRTH NO.   |  | 1. NAME OF DECEASED<br>(Type or Print) <b>George H. ISAAC</b>   |  |
| 2. DATE AND HOUR OF DEATH<br><b>10-28-69</b> <b>2 P.M.</b>  |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>3237 Phelps Lane Balto, Md.</b>  |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |  |
| 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Md.</b><br>B. COUNTY <b>2006</b>   |  | C. CITY OR TOWN <b>BALTIMORE</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| E. STREET AND NUMBER<br><b>3237 Phelps Lane</b>   |  | 5. SEX <b>M</b> 6. RACE <b>W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH <b>6/5/09</b> 9. AGE (In years last birthday) <b>60</b>  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Uniform Cutter</b>  |  |
| 11. BIRTHPLACE (State or foreign country) <b>A.A. Co. Md.</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |
| 13. FATHER'S NAME <b>WALTER ISAAC</b>   |  | 14. MOTHER'S MAIDEN NAME <b>Green</b>   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>  |  | 16. SOCIAL SECURITY NO. <b>212-05-7794</b>  |  |
| 17. INFORMANT <b>HILDA ISAAC</b>  |  | ADDRESS <b>3237 Phelps Lane</b>   |  |
| 18. <b>157.91</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Carcinoma Pharynx</b>   |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>4 months</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____   |  |
| 19. DATE OF OPERATION <b>0</b>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20A. AUTOPSY? (Yes or No) <b>NO</b>   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |  |
| 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>OCT. 1965</b> to <b>OCT. 28, 69</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>OCT. 27, 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ( <del>did not</del> ) view the body after death. |  |   |  |
| 23A. SIGNATURE <b>Morris B. Schreiber M.D.</b>  |  | 23B. DATE SIGNED <b>10.29-69</b>  |  |
| 23C. PHYSICIAN'S NAME (Type) <b>MORRIS B. SCHREIBER M.D.</b>  |  | 23D. ADDRESS <b>1519 W. Lombard St.</b>   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 24B. DATE <b>10/31/69</b>   |  |
| 24C. NAME OF CEMETERY or CREMATORY <b>Green Haven Cem.</b>  |  | 24D. LOCATION (City, town, or county) (State) <b>A.A. Co. Md.</b>   |  |
| 25A. DATE REC'D BY HEALTH DEPT. <b>OCT 29 1969</b>  |  | 25B. NAME OF REGISTRAR <b>Robert A. Taylor M.D.</b>   |  |
| 25C. FUNERAL DIRECTOR <b>George H. Schmale</b>  |  | ADDRESS <b>BALTO., MD.</b>  |  |

2001-20

2001-20

WALSH

K-520

69 10579 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 10579

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Grant King</b>   |  |  |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month <b>10</b> Day <b>19</b> Year <b>69</b> Hour <b>9:38 P.M.</b><br>Estimated <input type="checkbox"/> |  |  |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>36 Franklin Square Hospital</b>   |  |  |  | 3. DATE PRONOUNCED DEAD<br>Month <b>10</b> Day <b>19</b> Year <b>69</b> Hour <b>9:38 P.M.</b>  |  |  |  |
| 6. SEX <b>Male</b>   |  |  |  | 7. RACE <b>Negro</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. DATE OF BIRTH<br><b>April-5th-06</b>  |  |  |  | 10. AGE (In years lost birthday) <b>63</b>   |  | 11. BIRTHPLACE (State or foreign country) <b>Virginia</b>  |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |  |  | 13. FATHER'S NAME <b>Henry King</b>  |  | 14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>1802</b>         |  |
| 15. MOTHER'S MAIDEN NAME <b>Florence Hayes</b>   |  |  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes War # 2</b>  |  |  |  |
| 17. SOCIAL SECURITY NO. <b>213-07-2775</b>   |  |  |  | 18. INFORMANT ADDRESS <b>Shirley King 3042 Tioga Parkway</b>   |  |  |  |
| 19. CAUSE OF DEATH<br><b>E8901X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Carbon monoxide asphyxiation</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| 20A. DATE OF OPERATION <b>2</b>  |  |  |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |
| 21. AUTOPSY? (Yes or No) <b>yes</b>  |  |  |  |  |  |  |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>  |  |  |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>house</b>  |  |  |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>1109 Pierce St. 2nd floor</b>  |  |  |  | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>10 19 69 8:50</b>   |  |  |  |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |  |  | 22F. HOW DID INJURY OCCUR? <b>Found in house fire. (arson)</b>   |  |  |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/><br>CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Russell S. Fisher</b> M.D. DATE SIGNED <b>10-20-69</b><br>EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b> |  |  |  |  |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 24B. DATE <b>10/24/69</b>                            |  | 24C. NAME of CEMETERY or CREMATORY <b>Baltimore National</b>   |  | 24D. LOCATION (City, town, or county) (State) <b>Baltimore City</b>  |  |
| 25A. DATE REC'D BY HEALTH DEPT. <b>OCT 28 1969</b>   |  | 25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b> |  | 25C. FUNERAL DIRECTOR ADDRESS <b>Stetson D. Wilson 1913 W. Balto. Md</b>   |  | 25D. <b>Stetson D. Wilson</b>  |  |

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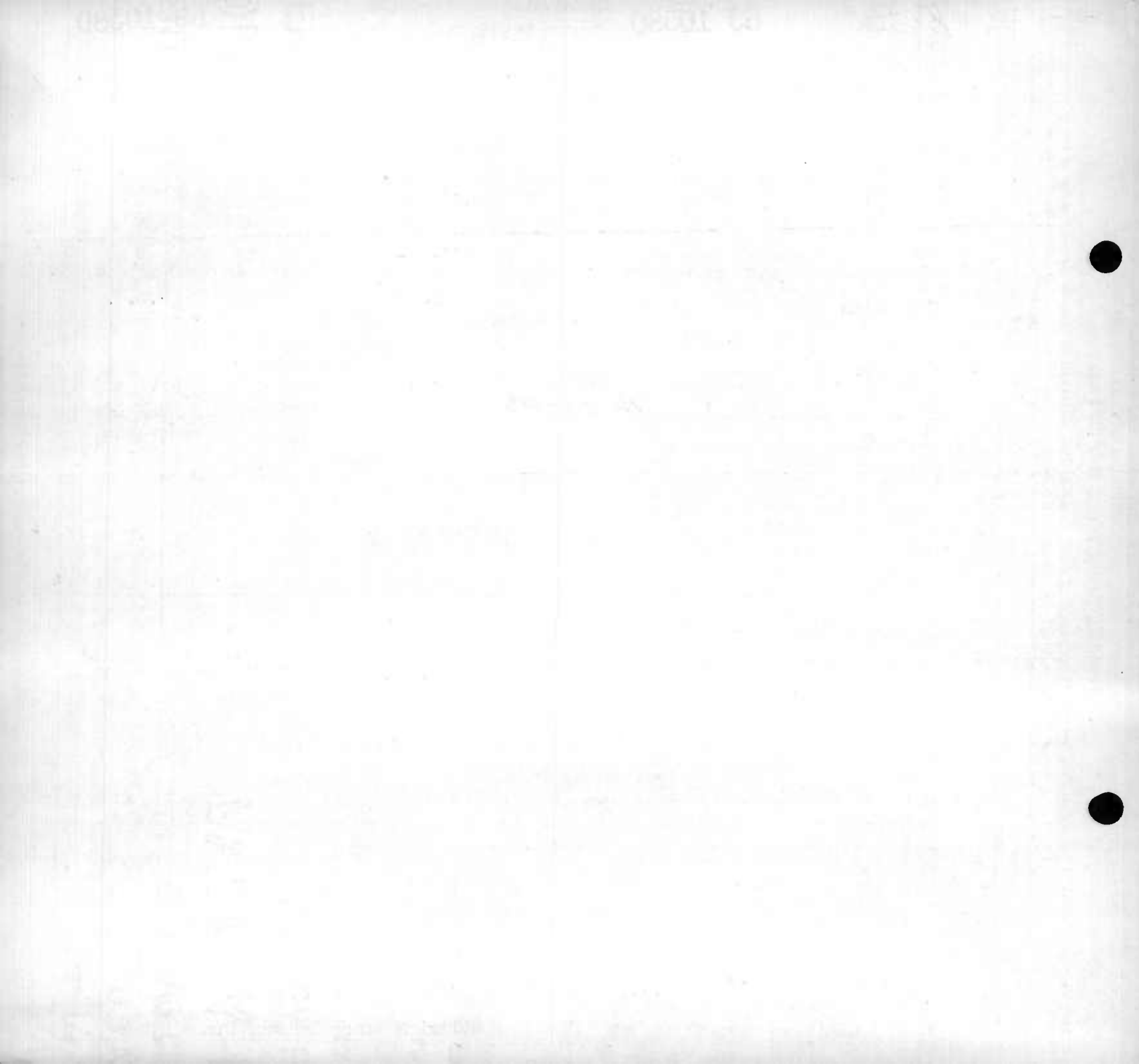
WALLEY



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                         |   |                                     |   |   |
|--|-------------------------|---|-------------------------------------|---|---|
| BIRTH NO.  |                         | BALTIMORE CITY HEALTH DEPARTMENT  |                                     | REG. NO. 69 10580   |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>ARTHUR R. BEATTIE</b>  |                         | 2. DATE AND HOUR OF DEATH<br><b>10/23/69 6:20 A.M.</b>  |                                     |   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                         | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>                |                                     |   |   |
| FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE CITY HOSPITALS</b><br><b>31</b> 4940 EASTERN AVENUE<br>BALTIMORE, MARYLAND #21224  |                         | C. CITY OR TOWN   |                                     | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
|  |                         | E. STREET AND NUMBER<br><b>3218 LYNCH ROAD #21219</b>   |                                     |   |   |
| 5. SEX<br><b>MALE</b>  | 6. RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>11-22-10</b> | 9. AGE (In years last birthday)<br><b>58</b>  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Custodian</b>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>School</b>  |                                     | 11. BIRTHPLACE (State or foreign country)<br><b>INDIANA</b>                                   |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                         | 13. FATHER'S NAME<br><b>DAVID BEATTIE</b>   |                                     |   |   |
| 14. MOTHER'S MAIDEN NAME<br><b>JEANNIE</b>   |                         | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                       |                                     |   |   |
| 16. SOCIAL SECURITY NO.<br><b>136-03-4113</b>  |                         | 17. INFORMANT RECORDS: <b>BALTIMORE CITY HOSPITALS</b><br>4940 EASTERN AVENUE #21224  |                                     |   |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>382.1</b><br><b>CAUSE OF DEATH</b>   |                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 weeks</b>  |                                     |   |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                         | (A) IMMEDIATE CAUSE <b>RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>6 weeks</b>  |                                     |   |   |
| (B) <b>SEPSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF:   |                         | (C) <b>DIVERTICULUS RHEUMATOID ARTHRITIS</b> <b>4.25.</b>   |                                     |   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |                         |   |                                     |   |   |
| 19A. DATE OF OPERATION<br><b>3/10/69</b>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>DIVERTICULITIS</b>   |                                     | 20A. AUTOPSY? (Yes or No) <b>YES</b>  |   |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>  |                         | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |                                     |   |   |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                         | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                                     |   |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                                     | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>9/21/69</b> 19 - to <b>10/23/69</b> 19 - that (I) (we) last saw the deceased alive on <b>10/23/69</b> 19 - and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |   |                                     |   |   |
| 23A. SIGNATURE<br>  |                         | 23B. DATE SIGNED<br><b>10/23/69</b>   |                                     | 23C. PHYSICIAN'S NAME (Type)<br><b>JOHN LORA</b>  |   |
| 23D. ADDRESS<br><b>6154 East Pratt St, Balt, Md.</b>   |                         | 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                     |   |   |
| 24B. DATE<br><b>10/27/69</b>   |                         | 24C. NAME of CEMETERY or CREMATORY<br><b>Belair Memorial Gardens</b>  |                                     | 24D. LOCATION (City, town, or county) (State)<br><b>Belair, Md.</b>                           |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 29 1969</b>  |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Talley, M.D.</b>   |                                     | 25C. FUNERAL DIRECTOR<br><b>Ullrich Funeral Home, Dundalk, Md.</b>                            |   |



## 69 10581 CERTIFICATE OF DEATH

REG. NO. 69 10581

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

M. Mitchell, Edith

2. DATE AND HOUR OF DEATH

10/24/69

1155 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITALS

4940 EASTERN AVENUE

BALTIMORE, MARYLAND 21224

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

3242 E. Baltimore St.

5. SEX

6. RACE

7. MARRIED ☒NEVER MARRIED ☐

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

If Under 1 Yr.

If Under 24 Hrs.

Female

White

WIDOWED ☐DIVORCED ☐

12/31/69

69

Months

Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Housewife

Maryland

USA

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

BARZELLA

UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

BCH RECORDS-4940 EASTERN AVE. BALTO. MD. 21224

18. 43391

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cerebrovascular Accident

Left Carotid Artery Thrombosis 10/18

(B) DUE TO, OR AS A CONSEQUENCE OF:

With recurrence 10/18

(C) DUE TO, OR AS A CONSEQUENCE OF:

7 days

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

Infection - Systemic

2 days

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10/15/69 to 10/24/69,  
that (I) (we) last saw the deceased alive on 10/24/69 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

10/24/69

23C. PHYSICIAN'S  
NAME (Type)

JOHN R. BURTON, MD.

DEGREE

23D. ADDRESS

BALTO. MD. 21224

BALTIMORE CITY HOSPITALS 4940 EASTERN AVE.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

BURIAL

10-28-69

HEREFORD BAPTIST CEMETERY

HEREFORD, BALTO. COUNTY, MD.

25A. DATE REC'D BY HEALTH DEPT

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

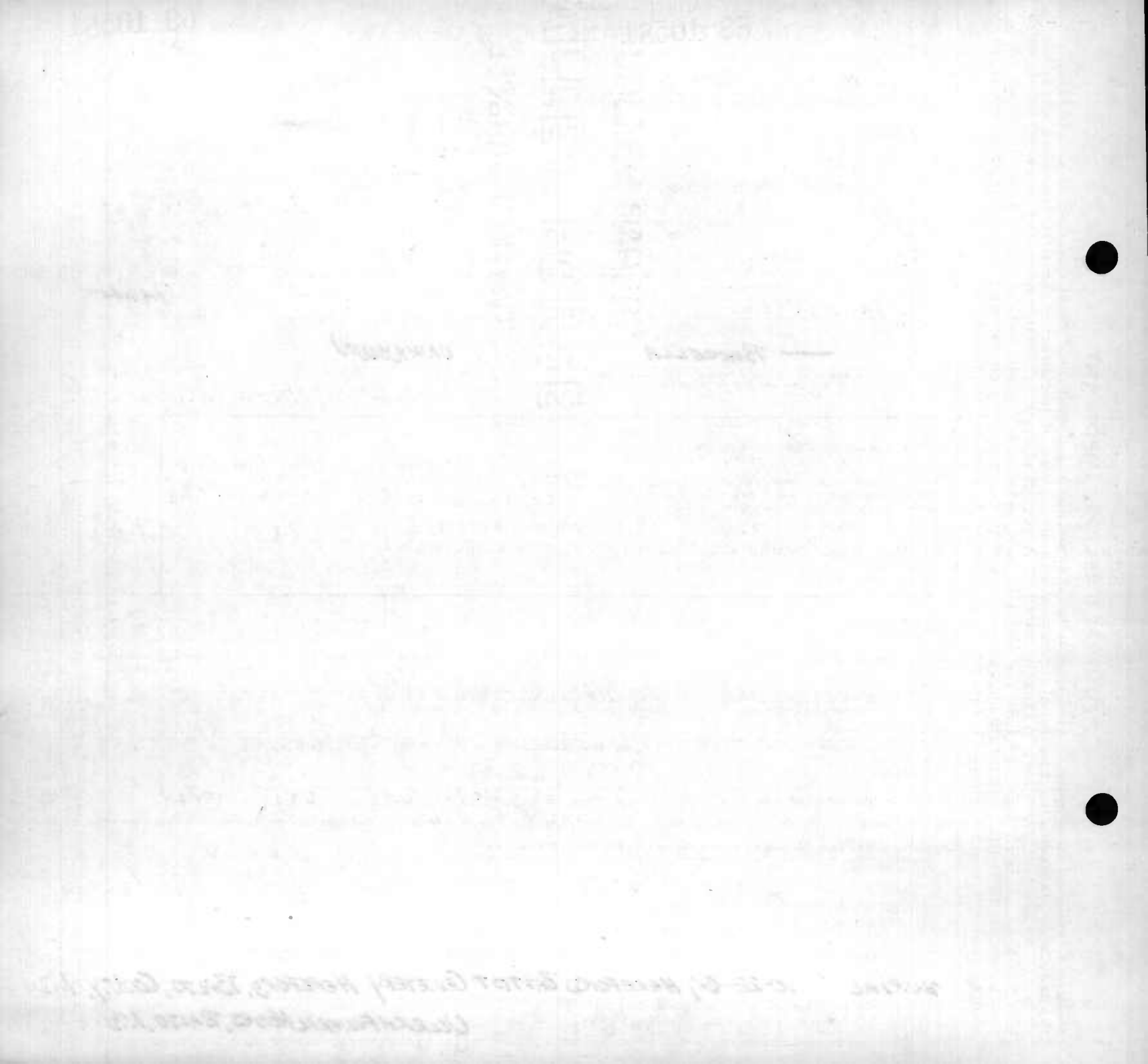
OCT 29 1969

Robert E. Gable, Jr.

WILLIAMS FUNERAL HOMES, BALTO. MD.

FUNERAL DIRECTOR: IMPORTANT

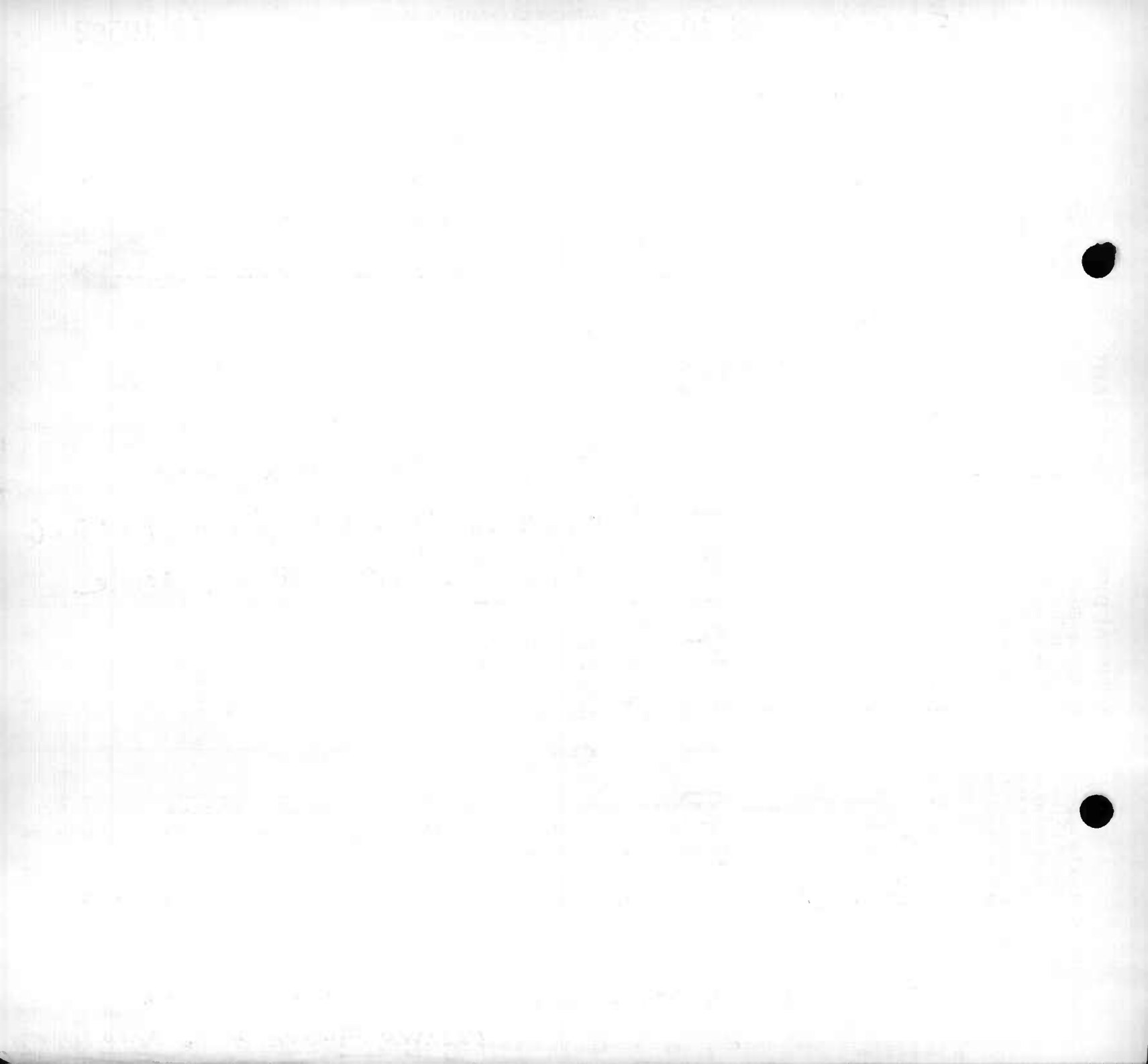
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

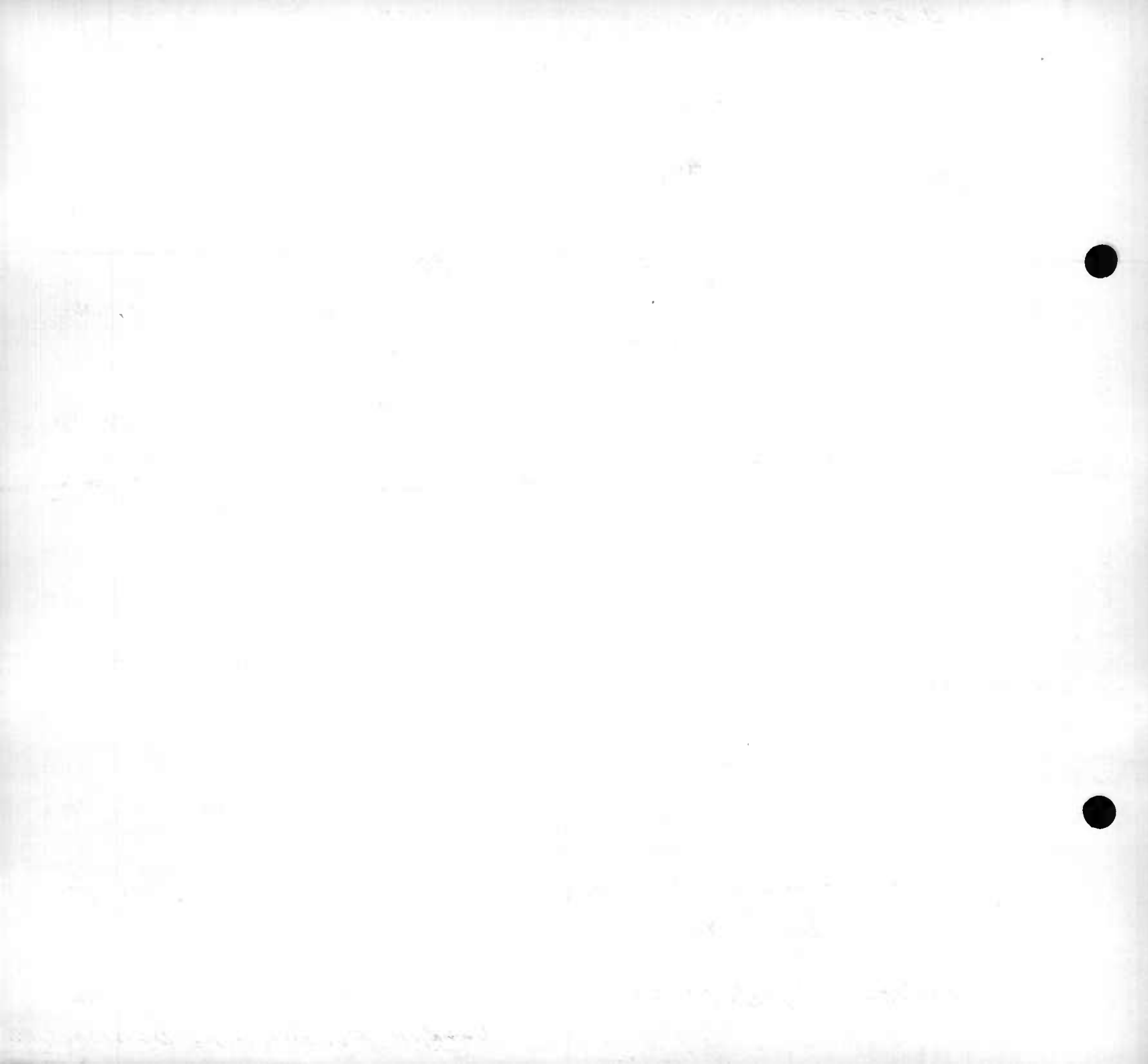
| F-630  |  |   |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | X  |  |
|--|--|---|--|---|--|--|--|
| 69 10582   |  |   |  | CERTIFICATE OF DEATH  |  | REG. NO. 69 10582  |  |
| 1. NAME OF DECEASED<br>(Type or Print)<br><i>Frances Marrian Frado</i>   |  |   |  | 2. DATE AND HOUR OF DEATH<br><i>10/24/69</i>   <i>2</i> <sup>40</sup> P.M.  |  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)   |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>South Baltimore General Hospital</i><br><i>43</i>   |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                      |  | A. STATE<br><i>Maryland Balto. Co.</i>  |  | B. COUNTY<br><i>5300</i>   |  |
| 5. SEX<br><i>Female</i>  |  | 6. RACE<br><i>Caucasian</i>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><i>6-6-01</i>                                    |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>housewife</i>  |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 9. AGE (In years last birthday)<br><i>68</i>  |  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.            |  |
| 11. BIRTHPLACE (State or foreign country)<br><i>Austria</i>  |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>US</i>   |  |  |  |
| 13. FATHER'S NAME<br><i>Andrew Hornack</i>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><i>Agnes Kineronski</i>   |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>no</i>  |  | 16. SOCIAL SECURITY NO.<br><i>215-05-9036</i>   |  | 17. INFORMANT<br><i>Evelyn Sauers</i>   |  |  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><i>Pulmonary edema &amp; congestion, severe</i><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><i>Acute, extensive Myocardial Infarction, H. ventricle</i><br><i>Generalized arteriosclerosis, severe</i> |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |  |   |  |   |  |  |  |
| 19A. DATE OF OPERATION<br><i>2</i>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>-</i>  |  | 20A. AUTOPSY? (Yes or No)<br><i>yes</i>   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><i>no</i>   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><i>none</i>   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)<br><i>-</i>  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?<br><i>-</i>  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>10-6</i> 19 <i>69</i> to <i>10-24</i> 19 <i>69</i> that (I) (we) last saw the deceased alive on <i>10-24</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 23A. SIGNATURE<br><i>Eleanor L. Mon M.D.</i>   |  |   |  | 23B. DATE SIGNED<br><i>10-24-69</i>   |  | 23C. PHYSICIAN'S NAME (Type)<br><i>Eleanor L. Mon</i>                |  |
| 23D. ADDRESS<br><i>4411 RICHMOND AVE. BALTIMORE, MD</i>  |  |   |  | 23E. NAME OF REGISTRAR<br><i>Robert E. Sauers, R.D.</i>   |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>BURIAL</i>  |  | 24B. DATE<br><i>10/28/69</i>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><i>OAK LAWN</i>   |  | 24D. LOCATION (City, town, or county) (State)<br><i>COLFATE MD</i>   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>OCT 29 1969</i>  |  | 25B. NAME OF REGISTRAR<br><i>Robert E. Sauers, R.D.</i>   |  | 25C. FUNERAL DIRECTOR<br><i>VLADIMIR FUNERAL HOME - DUNDALK MD</i>  |  |  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |   |  |
|---|---|--|
| <div style="display: flex; justify-content: space-between;"> <span>A-535</span> <span>69 10583</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>  |   | REG. NO. <span style="font-size: 1.5em;">69 10583</span>   |
| BIRTH NO. _____   |   | 2. DATE AND HOUR OF DEATH<br><div style="display: flex; justify-content: space-between;"> <span>10-24-1969</span> <span>1.25 A.M.</span> </div>  |
| 1. NAME OF DECEASED<br>(Type or Print) <span style="font-size: 1.2em;">Anthony, Gertrude</span>   |   | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br><div style="display: flex; justify-content: space-between;"> <span>A. STATE <span style="font-size: 1.2em;">Maryland</span></span> <span>B. COUNTY <span style="font-size: 1.2em;">Baltimore</span></span> </div> |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><span style="font-size: 1.2em;">South Baltimore General Hospital</span><br><span style="font-size: 1.5em;">43</span>   |   | C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span><br>D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |
| 5. SEX <span style="font-size: 1.2em;">Female</span>  |   | E. STREET AND NUMBER<br><span style="font-size: 1.2em;">3018 Dunleer Rd., Baltimore, Maryland</span>   |
| 6. RACE <span style="font-size: 1.2em;">White</span>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <span style="font-size: 1.2em;">7-30-1886</span>  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><span style="font-size: 1.2em;">Housewife</span>   |   | 9. AGE (In years last birthday) <span style="font-size: 1.2em;">83</span>  |
| 10B. KIND OF BUSINESS OR INDUSTRY<br><span style="font-size: 1.2em;">—</span>   |   | 11. BIRTHPLACE (State or foreign country)<br><span style="font-size: 1.2em;">Maryland</span>   |
| 13. FATHER'S NAME<br><span style="font-size: 1.2em;">James Meredith (dec)</span>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><span style="font-size: 1.2em;">U.S.A.</span>  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><span style="font-size: 1.2em;">No</span>   |   | 14. MOTHER'S MAIDEN NAME<br><span style="font-size: 1.2em;">Martha MEREDITH</span>   |
| 16. SOCIAL SECURITY NO.<br><span style="font-size: 1.2em;">—</span>   |   | 17. INFORMANT<br><span style="font-size: 1.2em;">Mrs Madeline Meredith</span>  |
| 18. <span style="font-size: 1.5em;">4124 I</span><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |   | ADDRESS<br><span style="font-size: 1.2em;">3018 Dunleer Rd. Balt. MD.</span>   |
| CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><span style="font-size: 1.2em;">Arterio-sclerotic Cardio-vascular disease, Bile lower lobe pneumonia</span><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><span style="font-size: 1.2em;">—</span><br>(C) <span style="font-size: 1.2em;">—</span>   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><span style="font-size: 1.2em;">—</span>   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><span style="font-size: 1.2em;">—</span>  |   |  |
| 19A. DATE OF OPERATION <span style="font-size: 1.2em;">None</span>  |   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><span style="font-size: 1.2em;">—</span>   |
| 20A. AUTOPSY? (Yes or No)<br><span style="font-size: 1.2em;">—</span>   |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><span style="font-size: 1.2em;">—</span>   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <span style="font-size: 1.2em;">No</span>   |   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><span style="font-size: 1.2em;">—</span>   |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><span style="font-size: 1.2em;">—</span>  |   | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br><span style="font-size: 1.2em;">—</span>  |
| 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |   | 21F. HOW DID INJURY OCCUR?<br><span style="font-size: 1.2em;">—</span>   |
| 22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">10-9-1969</span> to <span style="font-size: 1.2em;">10-24-1969</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">10-23-1969</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |   |  |
| 23A. SIGNATURE<br><span style="font-size: 1.2em;">N. Y. Younan</span>   |   | 23B. DATE SIGNED<br><span style="font-size: 1.2em;">10-24-69</span>  |
| 23C. PHYSICIAN'S NAME (Type)<br><span style="font-size: 1.2em;">Younan Yacoub Nabil M.D.</span>   |   | 23D. ADDRESS<br><span style="font-size: 1.2em;">South Baltimore General Hosp</span>  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><span style="font-size: 1.2em;">BURIAL</span>   |   | 24B. DATE<br><span style="font-size: 1.2em;">10/27/69</span>   |
| 24C. NAME OF CEMETERY or CREMATORY<br><span style="font-size: 1.2em;">MEXPOW RIDGE</span>   |   | 24D. LOCATION (City, town, or county) (State)<br><span style="font-size: 1.2em;">DORSEY MD</span>  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><span style="font-size: 1.2em;">OCT 29 1969</span>   |   | 25B. NAME OF REGISTRAR<br><span style="font-size: 1.2em;">—</span>   |
| 25C. FUNERAL DIRECTOR<br><span style="font-size: 1.2em;">VILLERICH, FUNERAL HOME, DUNDALIC MD</span>  |   | ADDRESS<br><span style="font-size: 1.2em;">—</span>  |

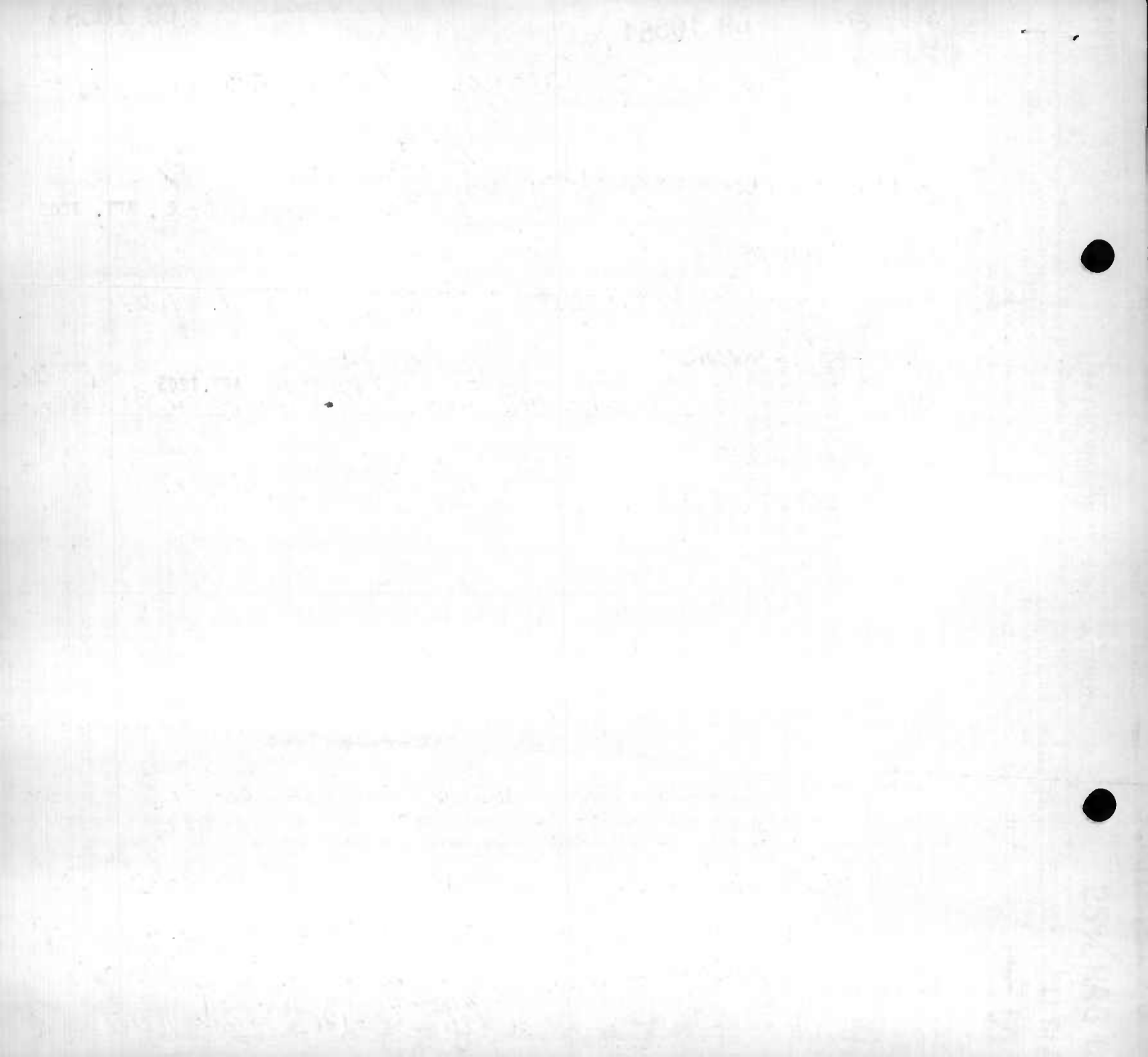




# FUNERAL DIRECTOR: IMPORTANT

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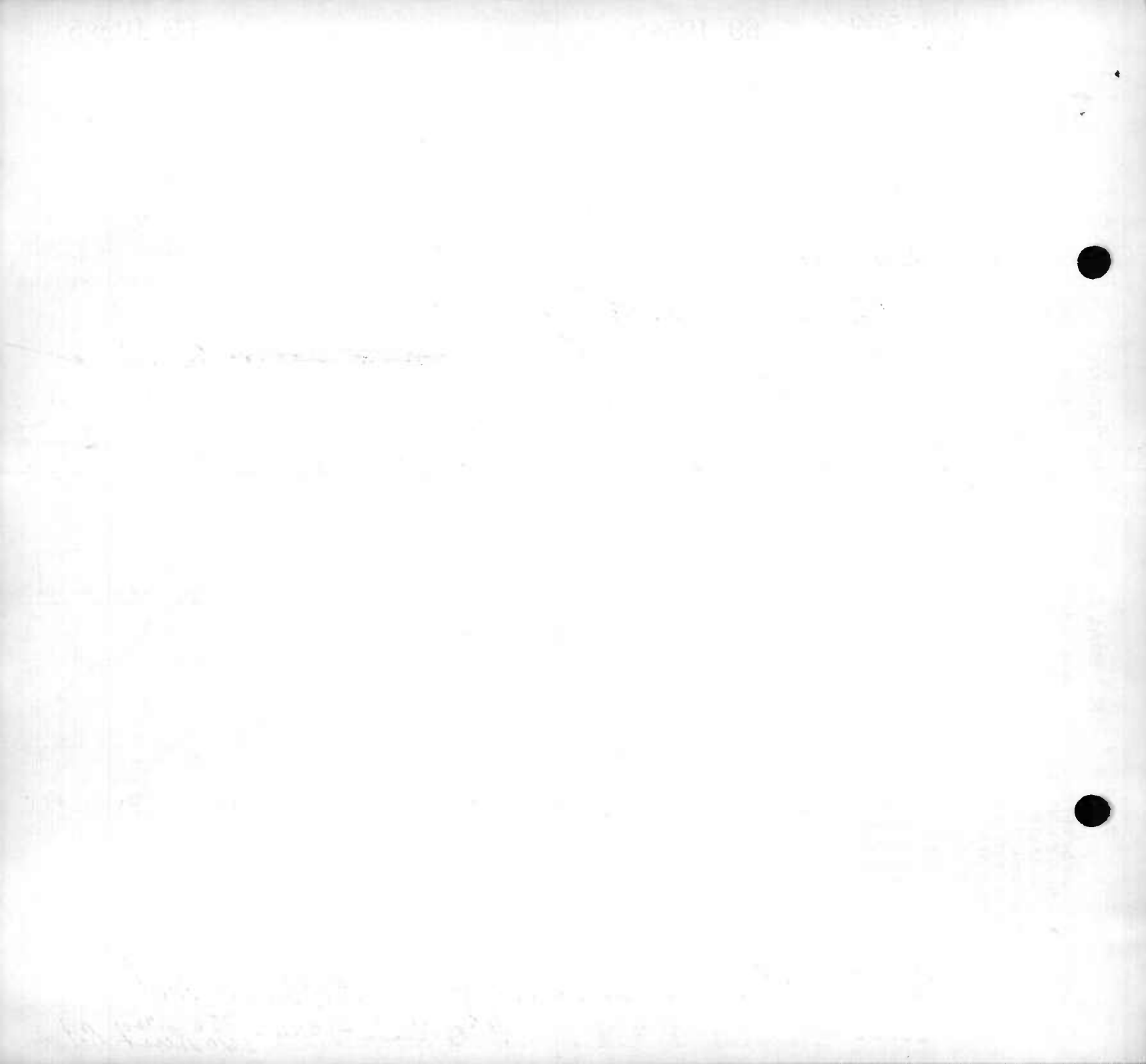
|   |         |  |                  |   |                                 |  |                        |
|---|---------|--|------------------|---|---------------------------------|--|------------------------|
| B-626   |         | 69 10584   |                  | BALTIMORE CITY HEALTH DEPARTMENT  |                                 | REG. NO. 69 10584  |                        |
| BIRTH NO.   |         | 1. NAME OF DECEASED<br>(Type or Print)   |                  | 2. DATE AND HOUR OF DEATH   |                                 |  |                        |
|   |         | Louis B Berger   |                  | October 25 / 69   |                                 | 11 A. M.   |                        |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |         |  |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)   |                                 |  |                        |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |         |  |                  | A. STATE B. COUNTY  |                                 |  |                        |
| 44 Union Memorial Hosp  |         |  |                  | Maryland 1307   |                                 |  |                        |
|   |         |  |                  | C. CITY OR TOWN   |                                 | D. INSIDE CITY LIMITS?   |                        |
|   |         |  |                  | Baltimore   |                                 | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                        |
|   |         |  |                  | E. STREET AND NUMBER  |                                 |  |                        |
|   |         |  |                  | 3838 Roland Ave, APT. 1203  |                                 |  |                        |
| 5. SEX  | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>    | 8. DATE OF BIRTH |   | 9. AGE (In years lost birthday) | 10. Under 1 Yr. Months   | 11. Under 24 Hrs. Days |
| Male  | White   | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                       | 66               |   |                                 |  |                        |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |         | 10B. KIND OF BUSINESS OR INDUSTRY  |                  | 11. BIRTHPLACE (State or foreign country)   |                                 | 12. CITIZEN OF WHAT COUNTRY?   |                        |
| Manager   |         | Restaurant   |                  | Baltimore, Md   |                                 | USA  |                        |
| 13. FATHER'S NAME   |         |  |                  | 14. MOTHER'S MAIDEN NAME  |                                 |  |                        |
| Joseph Berger   |         |  |                  | Rebecca   |                                 |  |                        |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |         | 16. SOCIAL SECURITY NO.  |                  | 17. INFORMANT   |                                 | ADDRESS  |                        |
| No  |         | 212-01-4441  |                  | Mrs. Edith Berger   |                                 | APT. 1203 3838 Roland Ave  |                        |
| 18. 412.4 I   |         | CAUSE OF DEATH   |                  |   |                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                         |                        |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |         | Anterograde cardiovascular disease - severe congestive heart failure                     |                  |   |                                 | 5 years  |                        |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)   |         | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                      |                  |   |                                 |  |                        |
| ANTECEDENT CAUSES   |         | (B) DUE TO, OR AS A CONSEQUENCE OF:  |                  |   |                                 |  |                        |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |         | (C) DUE TO, OR AS A CONSEQUENCE OF:  |                  |   |                                 |  |                        |
| II  |         |  |                  |   |                                 |  |                        |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |         |  |                  |   |                                 |  |                        |
| 19A. DATE OF OPERATION  |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                  | 20A. AUTOPSY? (Yes or No)   |                                 | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                        |
| 0   |         |  |                  |   |                                 |  |                        |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                                 |  |                        |
| 21D. TIME OF INJURY (APPROX.)   |         | 21E. INJURY OCCURRED   |                  | 21F. HOW DID INJURY OCCUR?  |                                 |  |                        |
| (Month) (Day) (Year) (Hour)   |         | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |                  |   |                                 |  |                        |
| 22. I certify that (I) (this hospital) attended the deceased from March 19 69 to Oct 16 19 69, that (I) (we) lost saw the deceased alive on Oct 16 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |         |  |                  |   |                                 |  |                        |
| 23A. SIGNATURE  |         |  |                  | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |                                 | 23B. DATE SIGNED   |                        |
| Yu-chen Lee   |         |  |                  |   |                                 | 10-26-69   |                        |
| 23C. PHYSICIAN'S NAME (Type)  |         |  |                  | 23D. ADDRESS  |                                 |  |                        |
| Yu-chen LEE   |         |  |                  | 1206 Frederick Rd, Balt 21228   |                                 |  |                        |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |         | 24B. DATE  |                  | 24C. NAME OF CEMETERY or CREMATORY  |                                 | 24D. LOCATION (City, town, or county) (State)                        |                        |
| Burial  |         | Oct 27 / 69  |                  | Hebrew Friendship   |                                 | Baltimore, Maryland  |                        |
| 25A. DATE REC'D BY HEALTH DEPT.   |         | 25B. NAME OF REGISTRAR   |                  | 25C. FUNERAL DIRECTOR   |                                 | ADDRESS  |                        |
| OCT 29 1969   |         | Robert E. Taylor, M.D.   |                  | Sol. Himmelfarb, Inc.   |                                 | 6000 Reest. Rd.  |                        |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

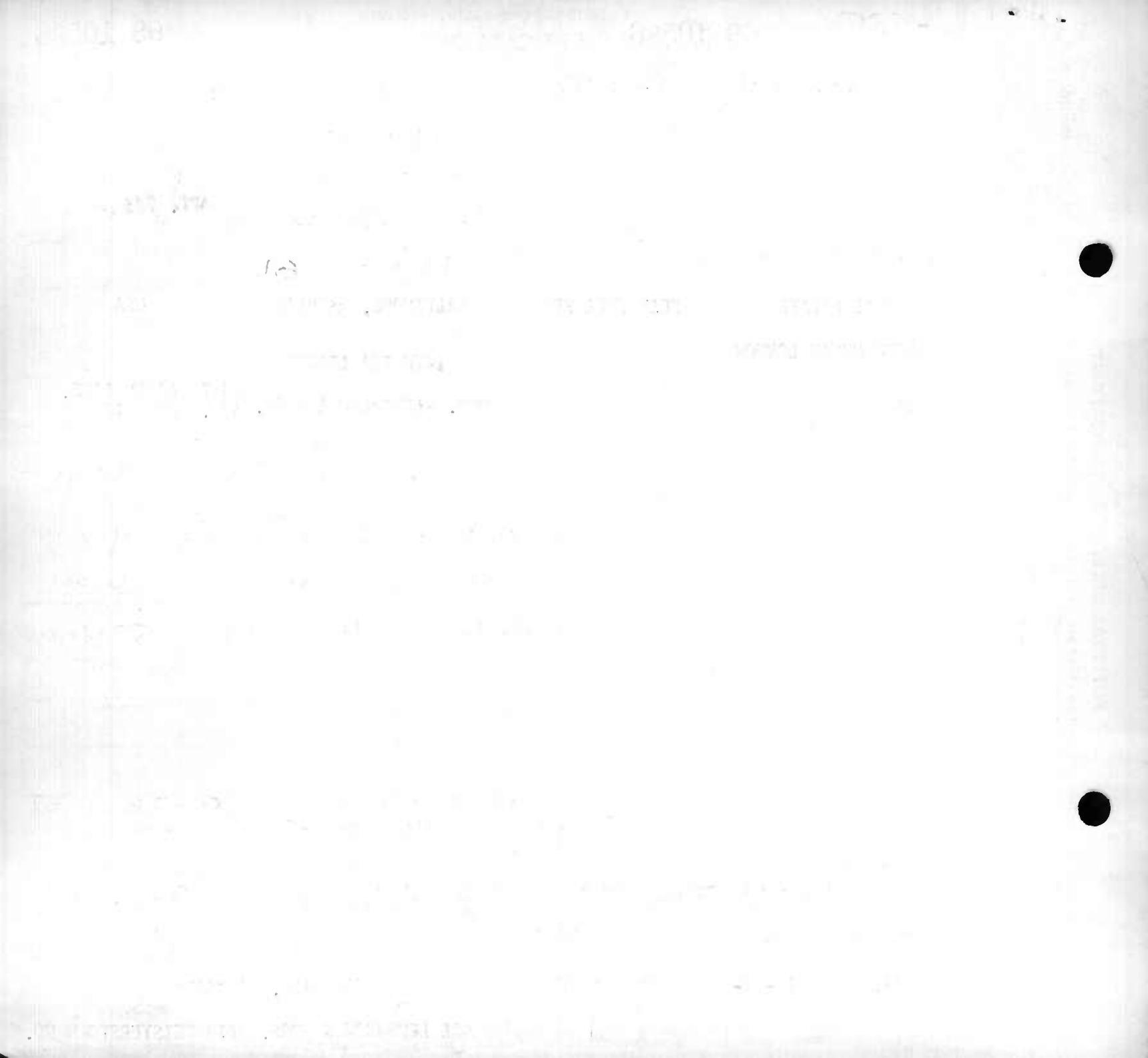
|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| W-520  |  | 69 10585   |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. 69 10585  |  |
| BIRTH NO.  |  |  |  | 1. NAME OF DECEASED<br>(Type or Print) ISRAEL WINIK   |  |  |  |
| 2. DATE AND HOUR OF DEATH<br>October 24/69 4:00 P.M.   |  |  |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>CHURCH HOME HOSPITAL   |  |  |  |
| 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE MARYLAND B. COUNTY 2730  |  |  |  | 5. SEX Male 6. RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  |  |
| C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  | E. STREET AND NUMBER 3311 ROMARIO CT. 09  |  |  |  |
| 8. DATE OF BIRTH 4-8-89  |  | 9. AGE (in years last birthday) 80   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor   |  | 11. BIRTHPLACE (State or foreign country) RUSSIA   |  |
| 12. CITIZEN OF WHAT COUNTRY? USA   |  | 13. FATHER'S NAME ABRAHAM WINIK  |  | 14. MOTHER'S MAIDEN NAME <del>REBECCA</del> CELIA   |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) |  |
| 16. SOCIAL SECURITY NO. 214-34-3376  |  | 17. INFORMANT SAMUEL WINIK   |  | ADDRESS 6614 DEANCROFT RD. 09   |  | 18. CAUSE OF DEATH   |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  |  |  | (A) IMMEDIATE CAUSE METASTATIC CA primary<br>DUE TO, OR AS A CONSEQUENCE OF: unknown<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:  |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br>GI HEMORRHAGE  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| 19A. DATE OF OPERATION 2   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No) YES   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                     |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  | 21D. TIME OF INJURY (Approx.)  |  |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?   |  | 22. I certify that (I) (this hospital) attended the deceased from October 13 19 69 to October 24 19 69 that (I) (we) last saw the deceased alive on October 24 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |
| 23A. SIGNATURE Corazon Z. Vergara, M.D. DEGREE   |  |  |  | 23B. DATE SIGNED October 24, 1969   |  | 23C. PHYSICIAN'S NAME (Type) CORAZON Z. VERGARA, M.D. DEGREE   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial  |  | 24B. DATE 10/26/69   |  | 24C. NAME OF CEMETERY OR CREMATORY Northwood Circle   |  | 24D. LOCATION (City, town, or county) Baltimore, Md. (State)   |  |
| 25A. DATE REC'D BY HEALTH DEPT. OCT 29 1969  |  | 25B. NAME OF REGISTRAR   |  | 25C. FUNERAL DIRECTOR   |  | ADDRESS 358 - 17000 640 Rust Rd.   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                         |   |                                    |   |  |   |  |
|--|-------------------------|---|------------------------------------|---|--|---|--|
| BIRTH NO. <b>L-535</b>   |                         | 69 10586  |                                    | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH  |  | REG. NO. <b>69 10586</b>  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>LONDON, SAMUEL</b>   |                         |   |                                    | 2. DATE AND HOUR OF DEATH<br><b>10-26-69 1530 A.M.</b>  |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                         |   |                                    | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)   |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>42 Sinai Hospital</b>   |                         | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |                                    | A. STATE<br><b>MARYLAND</b>   |  | B. COUNTY<br><b>2720</b>  |  |
|  |                         |   |                                    | C. CITY OR TOWN<br><b>BALTIMORE</b>   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
|  |                         |   |                                    | E. STREET AND NUMBER<br><b>3601 Clarks Ln</b>   |  | APT. # <b>703</b>   |  |
| 5. SEX<br><b>Male</b>  | 6. RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10/5/07</b> | 9. AGE (In years last birthday)<br><b>62</b>  | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>REAL ESTATE</b>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>SELF EMPLOYED</b>   |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>BALTIMORE, MARYLAND</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>LATE HYMAN LONDON</b>  |                         |   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>LATE IDA LERNER</b>  |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>  |                         | 16. SOCIAL SECURITY NO.   |                                    | 17. INFORMANT<br><b>MRS. ELIZABETH LONDON, 3601 CLARKS LANE, APT. 703 #15</b>   |  |   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.          |                         |   |                                    | CAUSE OF DEATH<br><b>Myocardial infarction</b>  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>days-</b>                                  |  |
|  |                         |   |                                    | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>Uremia &amp; probable</b>   |  |   |  |
|  |                         |   |                                    | (B) <b>Arteriosclerotic Cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>years</b>                           |  |   |  |
|  |                         |   |                                    | (C) <b>Ureteral Obstruction</b><br><b>years</b>   |  |   |  |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>Diabetes Mellitus</b>   |                         |   |                                    |   |  | <b>50 years</b>   |  |
| 19A. DATE OF OPERATION<br><b>0</b>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                    | 20A. AUTOPSY? (Yes or No)   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                    | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |  |   |  |
| 21D. TIME OF INJURY (Approx.)<br>(Month) (Day) (Year) (Hour)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                                    | 21F. HOW DID INJURY OCCUR?  |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10-8-69</b> 19 to <b>10-26</b> 19 <b>69</b> that (I) (we) last saw the deceased alive on <b>10-26</b> 19 <b>69</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |   |                                    |   |  |   |  |
| 23A. SIGNATURE<br><b>(Signature) MD</b>  |                         |   |                                    | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |  | 23B. DATE SIGNED<br><b>10-26-69</b>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Reuben DRISANSKI MD</b>   |                         |   |                                    | 23D. ADDRESS<br><b>Sinai Hospital of Balto</b>  |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                         | 24B. DATE<br><b>10-27-69</b>  |                                    | 24C. NAME OF CEMETERY or CREMATORY<br><b>SHOMRE ADATH</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>ROSEDALE, MARYLAND</b>                    |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 29 1969</b>  |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>   |                                    | 25C. FUNERAL DIRECTOR<br><b>SQL LEVINSON &amp; BROS. 6010 REISTERSTOWN RD.</b>  |  |   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                         |   |                                    |   |  |
|---|-------------------------|---|------------------------------------|---|--|
| S-536 69 10587  |                         | BALTIMORE CITY HEALTH DEPARTMENT  |                                    | REG. NO. 69 10587   |  |
| BIRTH NO. <del>000000000000</del>   |                         | 1. NAME OF DECEASED<br>(Type or Print) <b>ALBERT SCHNEIDER</b>  |                                    |   |  |
| 2. DATE AND HOUR OF DEATH<br><b>10-26-69 9:45 PM</b>  |                         | M.  |                                    |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><b>LEVINSON JEWISH INFIRMARY</b>  |                         | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>2720</b>  |                                    | C. CITY OR TOWN <b>BALTIMORE</b>  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>LEVINSON JEWISH INFIRMARY</b>  |                         | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |                                    | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| E. STREET AND NUMBER<br><b>3906 FORDS LANE, APT. 1 #21215</b>   |                         |   |                                    |   |  |
| 5. SEX<br><b>MALE</b>   | 6. RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                         | 8. DATE OF BIRTH<br><b>9-15-03</b> | 9. AGE (In years lost birthday)<br><b>66</b>  | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during 1 year immediately preceding death)<br><b>Reflex</b>   |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>SHOP</b>  |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>NEW YORK, N.Y.</b>                            |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>Yiddish</b>  |                         | 13. FATHER'S NAME<br><b>SIGMUND SCHNEIDER</b>   |                                    |   |  |
| 14. MOTHER'S MAIDEN NAME<br><b>FANNIE FRANK</b>   |                         | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |                                    |   |  |
| 16. SOCIAL SECURITY NO.   |                         | 17. INFORMANT<br><b>MRS. SHIRLEY SCHNEIDER, APT. 1 #21215</b>   |                                    |   |  |
| 18. <b>427.21</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>PNEUMONIA</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>CARDIO PULMONARY ARREST</b> |                         | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>CARDIO PULMONARY ARREST</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <b>CHRONIC BRAIN SYNDROME</b> |                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| MEDICAL CERTIFICATION   |                         |   |                                    |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>CHRONIC BRAIN SYNDROME</b>   |                         |   |                                    |   |  |
| 19A. DATE OF OPERATION<br><b>0</b>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                    | 20A. AUTOPSY? (Yes or No)   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)   |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                                    | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>11-21-68</b> 19 to <b>10-26-69</b> 19 that (I) (we) last saw the deceased alive on <b>10-26-69</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                         |   |                                    |   |  |
| 23A. SIGNATURE<br><b>Esquivel</b>   |                         | DEGREE<br>Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>   |                                    | 23B. DATE SIGNED<br><b>10-26-69</b>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>JULIO ESQUIVEL M.D.</b>  |                         | 23D. ADDRESS<br><b>LEVINSON</b>   |                                    |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                         | 24B. DATE<br><b>10-27-69</b>  |                                    | 24C. NAME OF CEMETERY or CREMATORY<br><b>HEBREW FRIENDSHIP</b>                                |  |
| 24D. LOCATION<br><b>3600 E. BALTO. ST. MARYLAND</b>   |                         | (City, town, or county) (State)   |                                    |   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 29 1969</b>   |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>   |                                    | 25C. FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BROS. 6010 REISTERSTOWN RD.</b>                |  |
| ADDRESS   |                         |   |                                    |   |  |

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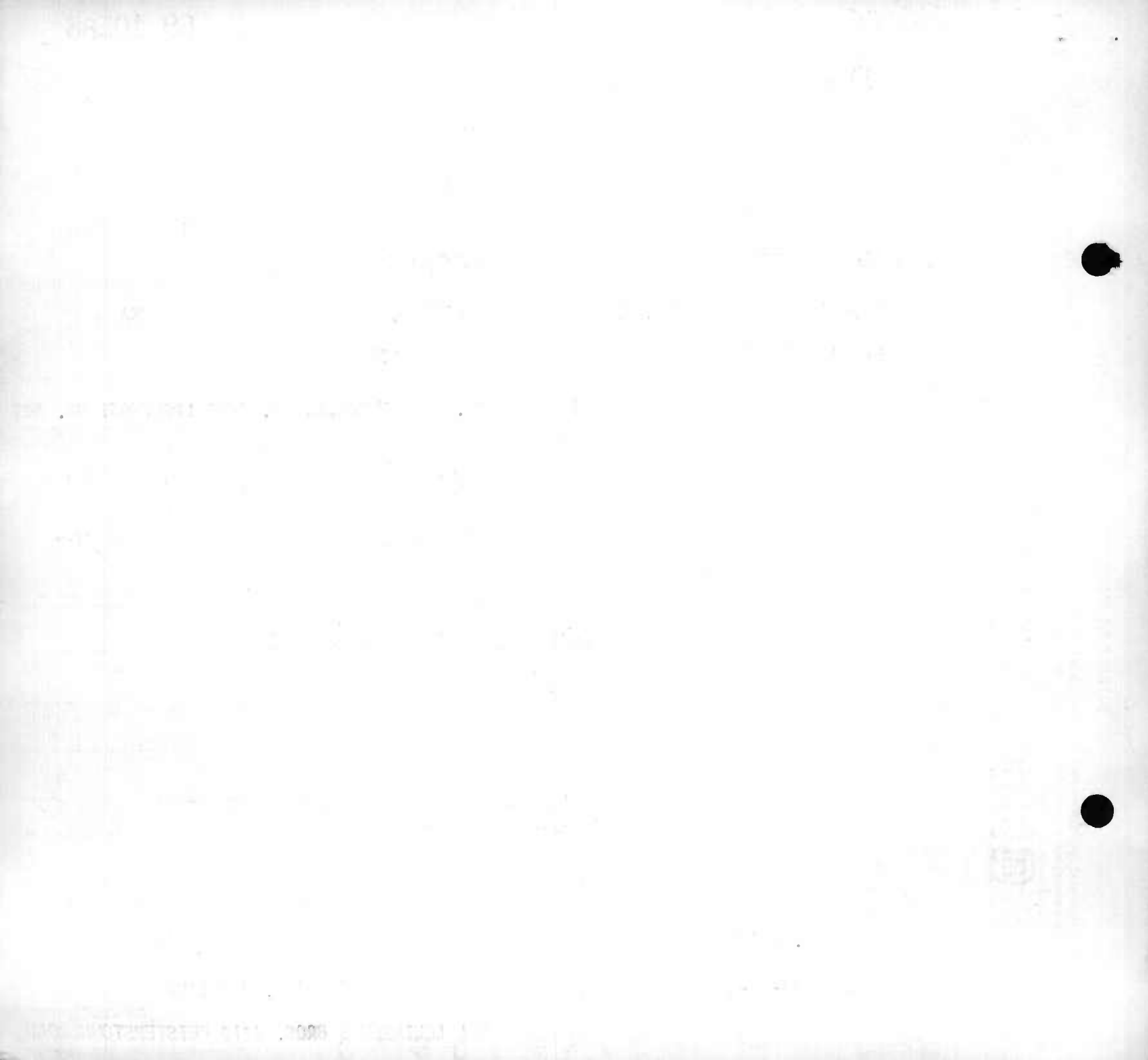
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# FUNERAL DIRECTOR: IMPORTANT

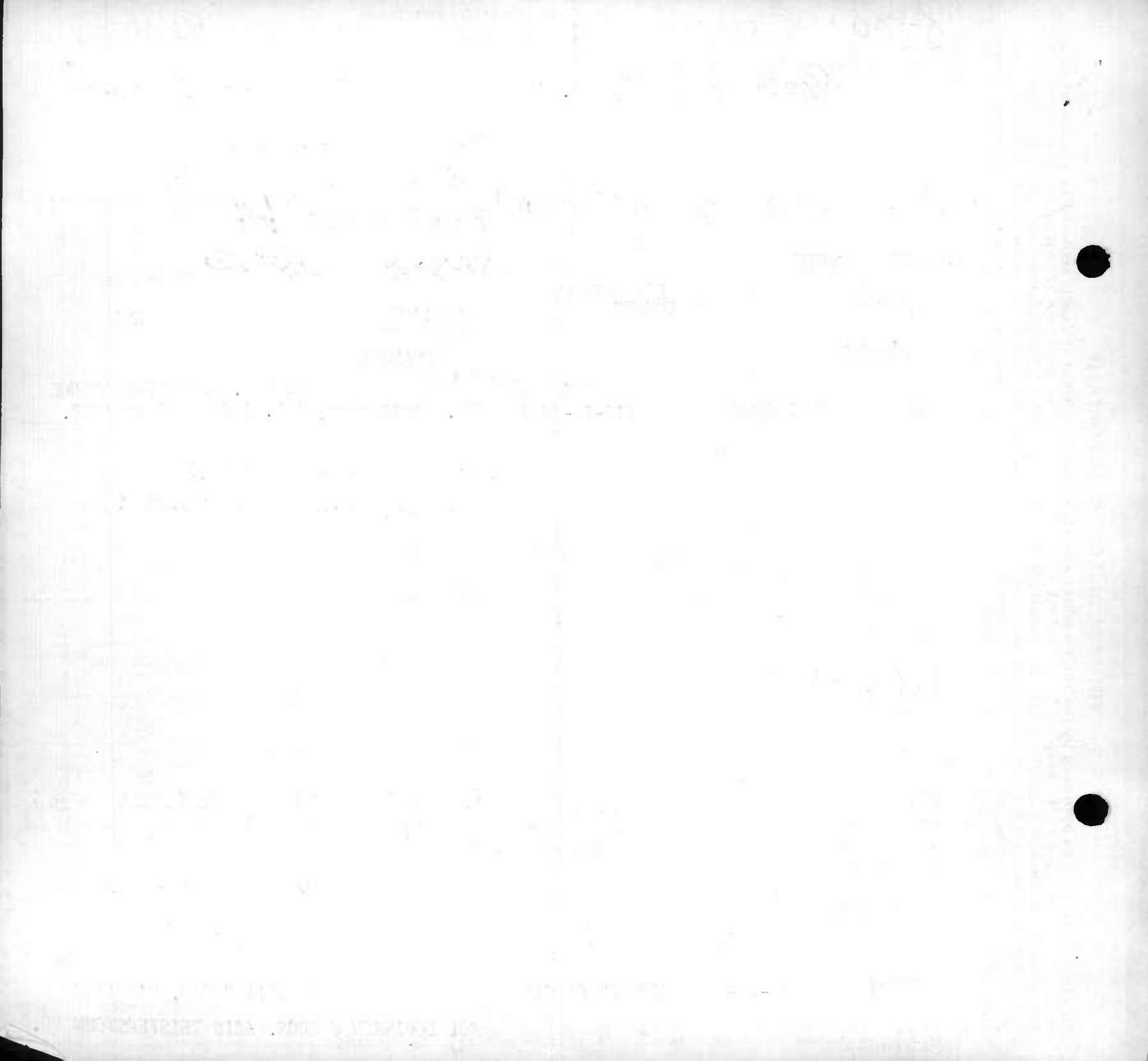
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                         |   |  |   |  |   |                              |
|--|-------------------------|---|--|---|--|---|------------------------------|
| F-635  |                         | BALTIMORE CITY HEALTH DEPARTMENT  |  | X   | REG. NO.                                     | 69 10588  |                              |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Dora Freedman</u>  |                         |   |  | 2. DATE AND HOUR OF DEATH<br><u>10/26/69</u> <u>8 PM</u>  |  |   |                              |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                         |   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                               |  |   |                              |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>42 Sinai Hosp. of Balt., Inc.</u>   |                         |   |  | A. STATE<br><u>Md.</u>  |  | B. COUNTY<br><u>Baltimore</u>   |                              |
|  |                         |   |  | C. CITY OR TOWN<br><u>BALTIMORE</u>   |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                              |
| E. STREET AND NUMBER<br><u>6819 Westridge Rd.</u>  |                         |   |  | #07   |  |   |                              |
| 5. SEX<br><u>FEMALE</u>  | 6. RACE<br><u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>XXXXXX</u>   | 9. AGE (in years last birthday)<br><u>77</u> | If Under 1 Yr. Months: Days: Hours: Min.  | If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>AT HOME</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>BUFFALO, NEW YORK</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |                              |
| 13. FATHER'S NAME<br><u>ABRAHAM DOBRES</u>   |                         |   |  | 14. MOTHER'S MAIDEN NAME<br><u>BESSIE ?</u>   |  |   |                              |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>NO</u>  |                         | 16. SOCIAL SECURITY NO.<br><u>NO</u>  |  | 17. INFORMANT<br><u>MRS. ROBERT ROSENBERG, 2405 LIGHTFOOT DR. #09</u>   |  |   |                              |
| 18. <u>410.9 10-230.9</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><u>Acute Myocardial Infarction</u><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>AS CVD</u><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><u>Diabetes mellitus.</u> |                         |   |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 hr.</u><br><u>10 yrs</u>                 |                              |
|  |                         |   |  |   |  |   |                              |
|  |                         |   |  |   |  |   |                              |
| 19A. DATE OF OPERATION<br><u>0</u>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |                              |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |  |   |                              |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |  |   |                              |
| 22. I certify that (I) (this hospital) attended the deceased from <u>July</u> 19 <u>68</u> to <u>Oct</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>Oct 26</u> 19 <u>69</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                         |   |  |   |  |   |                              |
| 23A. SIGNATURE<br><u>Solomon</u>   |                         |   |  | 23B. DATE SIGNED<br><u>10/26/69</u>   |  | 23C. PHYSICIAN'S NAME (Type)<br><u>S. SOLOMON</u>   |                              |
| 23D. ADDRESS<br><u>8600 LOCHMARV DR.</u>   |                         |   |  | 23E. FUNERAL DIRECTOR<br><u>SOL LEVINSON &amp; BROS.</u>  |  |   |                              |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |                         | 24B. DATE<br><u>10-27-69</u>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><u>SHAAREI ZION</u>   |  | 24D. LOCATION (City, town, or county) (State)<br><u>ROSEDALE, MARYLAND</u>                    |                              |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>OCT 29 1969</u>  |                         | 25B. NAME OF REGISTRAR<br><u>Robert E. Gabley, M.D.</u>   |  | 25C. FUNERAL DIRECTOR ADDRESS<br><u>6010 REISTERSTOWN ROAD</u>  |  |   |                              |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

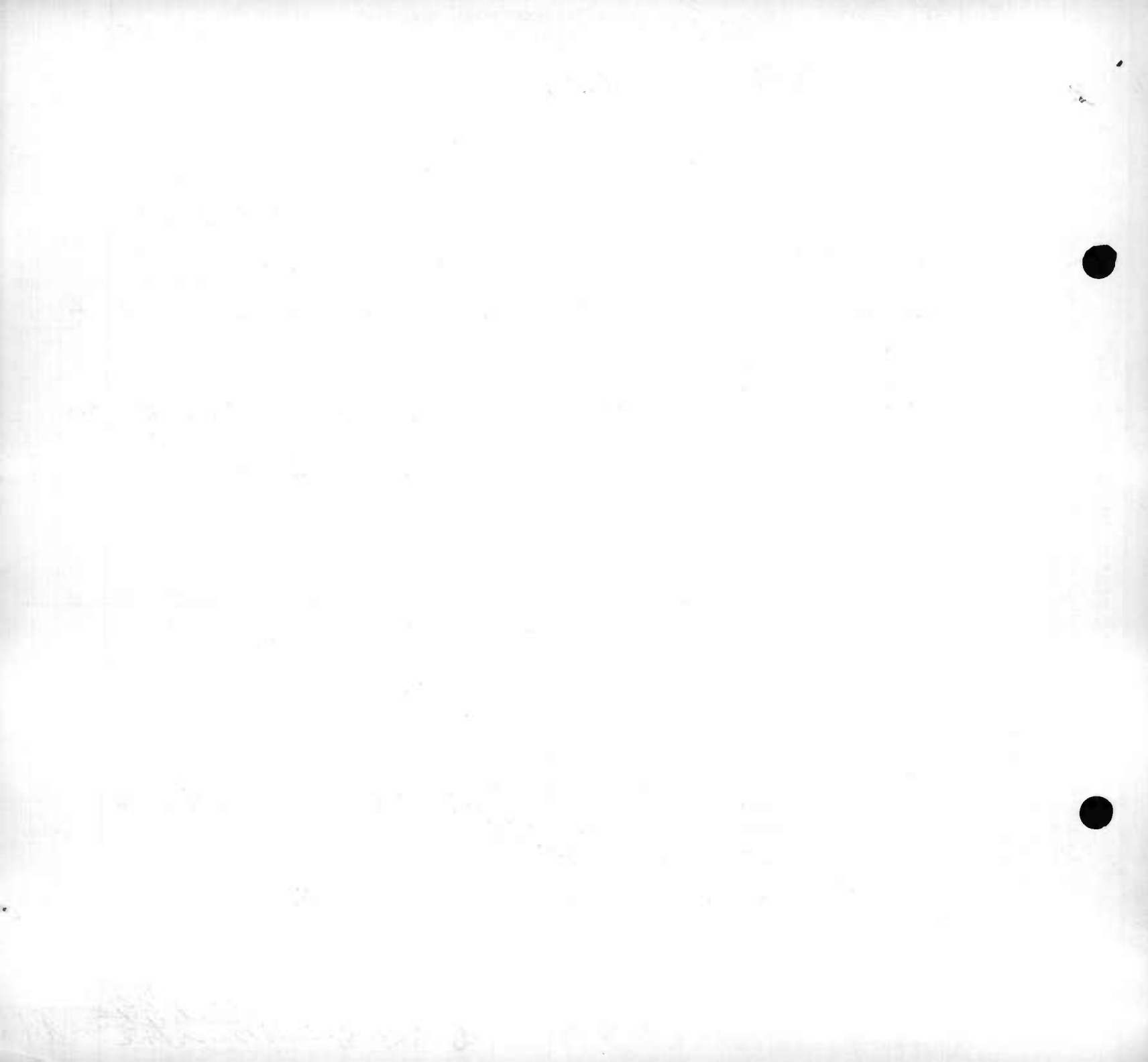
YS 150-REV. 1/1/68



# FUNERAL DIRECTOR: IMPORTANT

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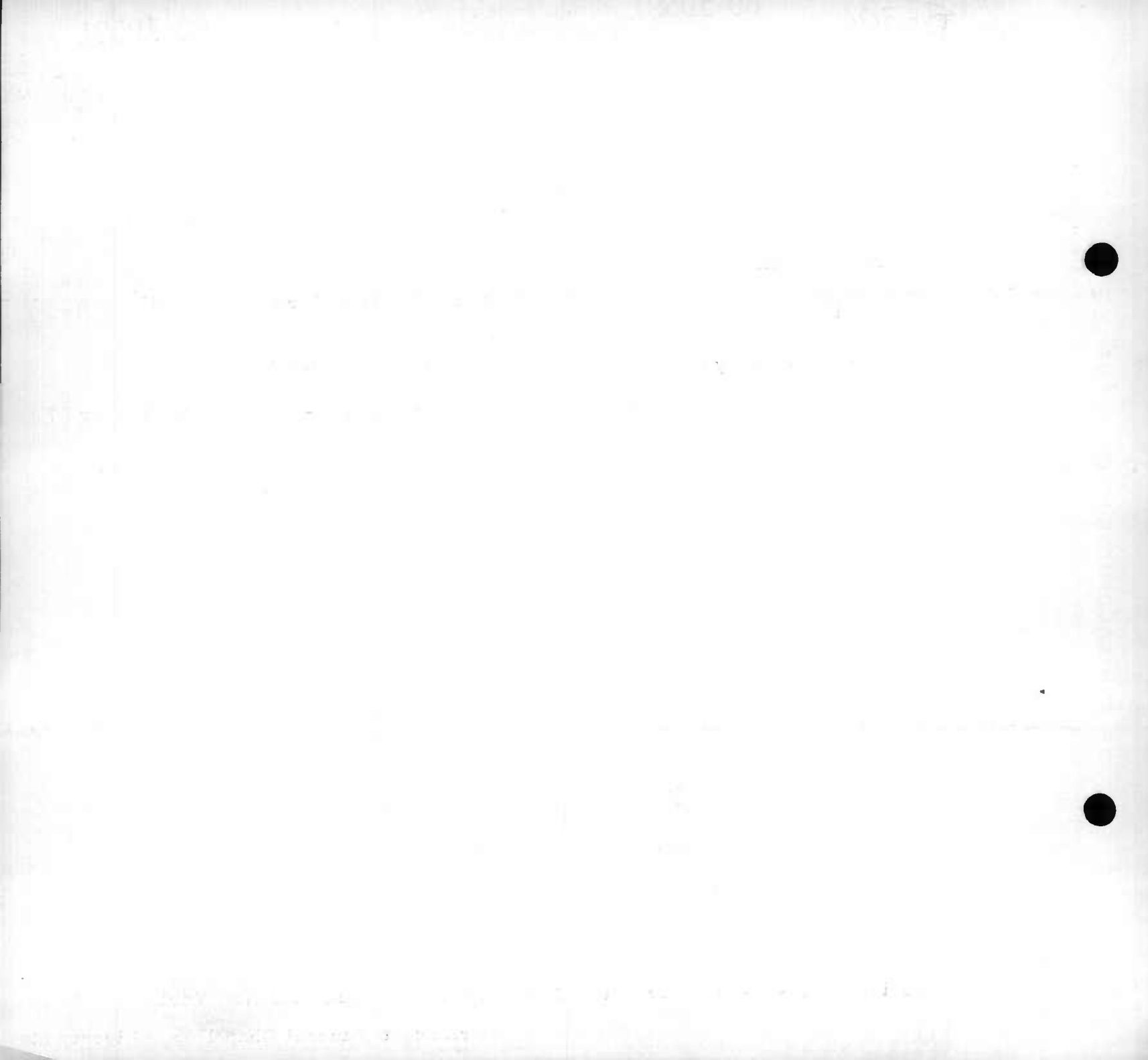
|   |                         |   |                                   |   |                            |   |                             |
|---|-------------------------|---|-----------------------------------|---|----------------------------|---|-----------------------------|
| S-632   |                         | 69 10590  |                                   | BALTIMORE CITY HEALTH DEPARTMENT  |                            | REG. NO. 69 10590   |                             |
| <b>CERTIFICATE OF DEATH</b>   |                         |   |                                   |   |                            |   |                             |
| 1. NAME OF DECEASED<br>(Type or Print) <u>LEOPOLD SCHWARTZ</u>  |                         |   |                                   | 2. DATE AND HOUR OF DEATH<br><u>10/24/69</u> <u>6:30 PM</u>   |                            |   |                             |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                         |   |                                   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)   |                            |   |                             |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>42 Sinai Hosp</u>  |                         |   |                                   | A. STATE <u>MARYLAND</u> B. COUNTY <u>P</u>   |                            |   |                             |
| IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION  |                         |   |                                   | C. CITY OR TOWN<br><u>BALTIMORE</u>   |                            | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                             |
|   |                         |   |                                   | E. STREET AND NUMBER<br><u>3904 ROSECREST RD</u>  |                            |   |                             |
| 5. SEX<br><u>Male</u>   | 6. RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>9/9/09</u> | 9. AGE (In years last birthday)<br><u>60</u>  | If Under 1 Yr. Months Days |   | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Salesman</u>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Retail</u>  |                                   | 11. BIRTHPLACE (State or foreign country)<br><u>Czechoslovakia</u>  |                            | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |                             |
| 13. FATHER'S NAME<br><u>Unknown</u>   |                         |   |                                   | 14. MOTHER'S MAIDEN NAME<br><u>Unknown</u>  |                            |   |                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>   |                         | 16. SOCIAL SECURITY NO.<br><u>219-26-7521</u>   |                                   | 17. INFORMANT<br><u>Mrs Barbara Schwartz - same</u>   |                            | ADDRESS   |                             |
| 18. <u>43391</u> CAUSE OF DEATH   |                         |   |                                   | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                             |
|   |                         |   |                                   | (A) IMMEDIATE CAUSE <u>Cerebral Thrombosis</u>  |                            | <u>7 days</u>   |                             |
|   |                         |   |                                   | DUE TO, OR AS A CONSEQUENCE OF:   |                            |   |                             |
|   |                         |   |                                   | (B) DUE TO, OR AS A CONSEQUENCE OF:   |                            |   |                             |
|   |                         |   |                                   | (C) DUE TO, OR AS A CONSEQUENCE OF:   |                            |   |                             |
| II  |                         |   |                                   |   |                            |   |                             |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                         |   |                                   | <u>Pneumonia</u>  |                            |   |                             |
| 19A. DATE OF OPERATION<br><u>0</u>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                   | 20A. AUTOPSY? (Yes or No)<br><u>No</u>  |                            | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                            |   |                             |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                                   | 21F. HOW DID INJURY OCCUR?  |                            |   |                             |
| 22. I certify that (1) (this hospital) attended the deceased from <u>10/18/69</u> 19__ to <u>10/24/69</u> 19__ that (1) (we) last saw the deceased alive on <u>10/24/69</u> 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. |                         |   |                                   |   |                            |   |                             |
| 23A. SIGNATURE<br><u>G. M. Vandy</u>  |                         |   |                                   | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |                            | 23B. DATE SIGNED<br><u>10/24/69</u>   |                             |
| 23C. PHYSICIAN'S NAME (Type)  |                         |   |                                   | 23D. ADDRESS  |                            |   |                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |                         | 24B. DATE<br><u>10/26/69</u>  |                                   | 24C. NAME OF CEMETERY OR CREMATORY<br><u>Shoreline Memorial</u>   |                            | 24D. LOCATION (City, town, or county) (State)<br><u>Baltimore, Md.</u>                        |                             |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>OCT 29 1969</u>   |                         | 25B. NAME OF REGISTRAR<br><u>John E. Jones</u>  |                                   | 25C. FUNERAL DIRECTOR<br><u>John E. Jones</u>   |                            | ADDRESS<br><u>615 Lexington Rd</u>  |                             |



# FUNERAL DIRECTOR: IMPORTANT

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| BALTIMORE CITY HEALTH DEPARTMENT   |  |   |  | REG. NO. 69 10591  |   |
|--|--|---|--|--|---|
| BIRTH NO. 5-300  |  |   |  | CERTIFICATE OF DEATH   |   |
| 1. NAME OF DECEASED<br>(Type or Print) Kathryn Sadowy  |  |   | 2. DATE AND HOUR OF DEATH<br>10/25/69 1:30 PM  |  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>Maryland General Hosp.   |  |   | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)<br>A. STATE <del>BALTO</del> B. COUNTY Balto |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>Maryland General Hosp.  |  |   | C. CITY OR TOWN<br>Balto   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |
| 5. SEX Female  |  |   | 6. RACE White  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife   |  |   | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 8. DATE OF BIRTH<br>6/27/1916   |
| 13. FATHER'S NAME<br>Andrew Fedyk  |  |   | 14. MOTHER'S MAIDEN NAME<br>Anna Kardan  |  | 9. AGE (In years last birthday)<br>53   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO   |  |   | 16. SOCIAL SECURITY NO.<br>NO  |  | 11. BIRTHPLACE (State or foreign country)<br>Rochester New York   |
| 17. INFORMANT<br>Theodore Sadowy-2117 Meadowview Dr #7   |  |   | 12. CITIZEN OF WHAT COUNTRY?<br>U. S. A  |  |   |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>Cirrrosis of liver.<br>portal hypertension.<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CAUSE last.<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) GI bleeding.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |  |   |  |  |   |
| 19A. DATE OF OPERATION   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br>NO  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from 10/16/69 to 10/25/69 that (I) (we) lost saw the deceased alive on 10/25/69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |  |   |  |  |   |
| 23A. SIGNATURE<br>Michael J. Taylor  |  |   |  | 23B. DATE SIGNED<br>10/25/69   |   |
| 23C. PHYSICIAN'S NAME (Type)<br>Michael J. Taylor, M.D.  |  |   |  | 23D. ADDRESS<br>ArmaCost Funeral Chapel 4600 Liberty Hts                 |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial   |  | 24B. DATE<br>10-28-69   |  | 24C. NAME of CEMETERY or CREMATORY<br>Riverside Cemetery                 |   |
| 24D. LOCATION<br>Rochester New York  |  | 24E. NAME of REGISTRAR<br>Robert E. Taylor, M.D.  |  | 24F. FUNERAL DIRECTOR<br>ArmaCost Funeral Chapel 4600 Liberty Hts        |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br>OCT 29 1969   |  | 25B. NAME OF REGISTRAR<br>Robert E. Taylor, M.D.  |  | 25C. FUNERAL DIRECTOR<br>ArmaCost Funeral Chapel 4600 Liberty Hts        |   |





# FUNERAL DIRECTOR: IMPORTANT

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| BALTIMORE CITY HEALTH DEPARTMENT   |                                |   |   | X REG. NO. 69 10592  |   |
|--|--------------------------------|---|---|--|---|
| <b>BIRTH NO.</b><br><b>1. NAME OF DECEASED</b><br>(Type or Print) <b>Roy, JOHN L. SR.</b>  |                                | <b>2. DATE AND HOUR OF DEATH</b><br><b>10-24-69. 6-15 A. M.</b>   |   |  |   |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><br><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Lutheran Hospital of MD.</b>   |                                | <b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)<br><b>A. STATE</b> <b>MD</b> <b>B. COUNTY</b> <b>BALTO.</b><br><b>C. CITY OR TOWN</b> <b>Baltimore</b> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br><b>E. STREET AND NUMBER</b> <b>5300 3332 Kessler ct.</b> |   |  |   |
| <b>5. SEX</b><br><b>M</b>  | <b>6. RACE</b><br><b>White</b> | <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>   | <b>8. DATE OF BIRTH</b><br><b>9-12-96.</b>            | <b>9. AGE</b> (In years last birthday) <b>73 yrs.</b>  | <b>If Under 1 Yr. Months: Days: Hours: Min.</b><br><b>If Under 24 Hrs. Min.</b> |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Chauffeur</b>   |                                | <b>10B. KIND OF BUSINESS OR INDUSTRY</b><br><b>Cab</b>  |   | <b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b> |   |
| <b>13. FATHER'S NAME</b><br><b>John R. Roy</b>   |                                |   | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Lottie Ogle</b> |  |   |
| <b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                                | <b>16. SOCIAL SECURITY NO.</b><br><b>213-02-1544A</b>   |   | <b>17. INFORMANT</b> <b>John L. Roy Jr.</b> <b>ADDRESS</b> <b>3332 Kessler Court</b>                                 |   |
| <b>18. CAUSE OF DEATH</b><br><b>18A. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Antecedent Causes</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b> |                                |   |   |  |   |
| <b>18B. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b><br><b>4 10, 91</b>  |                                |   |   |  |   |
| <b>18C. MEDICAL CERTIFICATION</b><br><b>19A. DATE OF OPERATION</b> <b>0 -</b> <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>-</b> <b>20A. AUTOPSY?</b> (Yes or No) <b>No</b> <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> <b>-</b>   |                                |   |   |  |   |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>  |                                | <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>-</b>  |   | <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) <b>-</b>                             |   |
| <b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.) <b>-</b>  |                                | <b>21E. INJURY OCCURRED</b><br>While At Work <input type="checkbox"/> - Not While At Work <input type="checkbox"/>  |   | <b>21F. HOW DID INJURY OCCUR?</b> <b>-</b>   |   |
| <b>22. I certify that (I) (this hospital) attended the deceased from 10 - 14 - 19 69 to 10 - 24 - 19 69, that (I) (we) last saw the deceased alive on 10 - 24 - 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>   |                                |   |   |  |   |
| <b>23A. SIGNATURE</b><br><b>KANTILAL J. SHAH M.D.</b>  |                                |   |   | <b>23B. DATE SIGNED</b><br><b>10/24/69</b>   |   |
| <b>23C. PHYSICIAN'S NAME</b> (Type)<br><b>KANTILAL J. SHAH M.D.</b>  |                                |   |   | <b>23D. ADDRESS</b><br><b>Lutheran Hospital of MD.</b>   |   |
| <b>24A. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><b>Burial</b>  |                                | <b>24B. DATE</b><br><b>10/27/69</b>   |   | <b>24C. NAME OF CEMETERY or CREMATORY</b><br><b>New Baltimore</b>  |   |
| <b>24D. LOCATION</b> (City, town, or County) (State)<br><b>Baltimore, Maryland</b>   |                                | <b>25A. DATE REC'D BY HEALTH DEPT.</b><br><b>OCT 29 1969</b>  |   |  |   |
| <b>25B. NAME OF REGISTRAR</b><br><b>Robert E. Fisher</b>   |                                | <b>25C. FUNERAL DIRECTOR</b><br><b>1325 Sulphur Sp Rd.</b>  |   |  |   |

SECRET

SECRET



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |                                |  |  | REG. NO. <b>69 10593</b>   |
|--|--------------------------------|--|--|--|
| <b>1. NAME OF DECEASED</b><br>(Type or Print) <i>Mrs. Clarabelle Dawson</i>  |                                | <b>2. DATE AND HOUR OF DEATH</b><br><i>10-28-1969</i> <span style="float: right;"><i>7:30 A.M.</i></span>  |  |  |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><i>44 Union Mem. Hospital</i>  |                                | <b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission)<br>A. STATE <i>Md</i> B. COUNTY <i>2711</i><br><br><b>C. CITY OR TOWN</b> <i>Baltimore</i> <b>D. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input type="checkbox"/><br><br><b>E. STREET AND NUMBER</b><br><i>400 Rossiter Ave</i>   |  |  |
| <b>5. SEX</b><br><i>Female</i>   | <b>6. RACE</b><br><i>White</i> | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>   | <b>8. DATE OF BIRTH</b><br><i>2-3-1886</i> | <b>9. AGE</b> (In years last birthday)<br><i>83</i>  |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>   |                                | <b>10B. KIND OF BUSINESS OR INDUSTRY</b><br><i>Home</i>  |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><i>Baltimore, Md</i>                   |
| <b>12. CITIZEN OF WHAT COUNTRY?</b>  |                                | <b>13. FATHER'S NAME</b><br><i>Franklin Johnson</i>  |  |  |
| <b>14. MOTHER'S MAIDEN NAME</b><br><i>Jennie Stoner</i>  |                                | <b>15. Was Deceased Ever in U. S. Armed Forces?</b><br>(Yes, no or unknown) (If yes, give war or dates of service)<br><i>no no</i>   |  |  |
| <b>16. SOCIAL SECURITY NO.</b><br><i>220 44 3357</i>   |                                | <b>17. INFORMANT</b> <i>Chas Dawson 400 Rossiter Ave</i> <b>ADDRESS</b>  |  |  |
| <b>18. CAUSE OF DEATH</b><br><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>412.4 I Acute myocardial infarction -</i><br><b>(A) IMMEDIATE CAUSE</b> <i>Myocardial Disease</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br><b>(B)</b> _____<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br><b>(C)</b> _____<br><br><b>II</b><br><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b> |                                |  |  | <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b><br><i>2 yrs.</i>                       |
| <b>19A. DATE OF OPERATION</b><br><i>0</i>  |                                | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>  |  | <b>20A. AUTOPSY?</b> (Yes or No)<br><i>No</i>  |
| <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>  |                                | <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>  |  |  |
| <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                | <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)  |  |  |
| <b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)   |                                | <b>21E. INJURY OCCURRED</b><br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  |  |
| <b>21F. HOW DID INJURY OCCUR?</b>  |                                | <b>22. I certify that (I) (this hospital) attended the deceased from</b> <i>Sept. 10</i> <b>19</b> <i>69</i> <b>to</b> <i>Oct.</i> <b>19</b> <i>69</i> , <b>that (I) (we) last saw the deceased alive on</b> <i>Oct. 21</i> <b>19</b> <i>69</i> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (they) (did not) view the body after death.</b> |  |  |
| <b>23A. SIGNATURE</b><br><i>Com. H. Kammer J.</i> <b>DEGREE</b>  |                                | <b>23B. DATE SIGNED</b><br><i>28 Oct. 1969</i>   |  | <b>23C. PHYSICIAN'S NAME</b> (Type)<br><b>DEGREE</b>                                       |
| <b>23D. ADDRESS</b><br><i>6011 York Rd. Balto. Md. 21212</i>   |                                | <b>24A. BURIAL CREMATION, REMOVAL (Specify)</b><br><i>burial</i>   |  |  |
| <b>24B. DATE</b><br><i>10-30-69</i>  |                                | <b>24C. NAME OF CEMETERY or CREMATORY</b><br><i>Lorraine Ph Cem</i>  |  | <b>24D. LOCATION</b> (City, town, or county) (State)<br><i>Baltd Md</i>                    |
| <b>25A. DATE REC'D BY HEALTH DEPT.</b><br><i>OCT 28 1969</i>   |                                | <b>25B. NAME OF REGISTRAR</b><br><i>Robert E. Taylor, M.D.</i>   |  | <b>25C. FUNERAL DIRECTOR</b> <i>Thomas Henry Inc</i> <b>ADDRESS</b> <i>1600 HOLLINS ST</i> |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| D-640   |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | 69 10594 CERTIFICATE OF DEATH   |  | REG. NO. 69 10594  |  |
| BIRTH NO.   |  |  |  | 1. NAME OF DECEASED<br>(Type or Print) <b>Droll, Marie, I., (MARY A.)</b>   |  |  |  |
| 2. DATE AND HOUR OF DEATH<br><b>10/26/69 1:00 P.M.</b>  |  |  |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  |  |  |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>WA Baltimore</b>  |  |  |  | 5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>BALTIMORE CITY HOSPITALS</b><br><b>4940 EASTERN AVENUE</b><br><b>BALTIMORE, MARYLAND 21224</b> |  |  |  |
| 6. CITY OR TOWN<br><b>HARBORVIEW</b>  |  |  |  | 7. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 8. STREET AND NUMBER<br><b>518 S. 48th ST. #21224</b>   |  |  |  | 9. SEX <b>FEMALE</b> 10. RACE <b>WHITE</b>  |  |  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>BALTIMORE, MD.</b>  |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>   |  |  |  |
| 13. FATHER'S NAME<br><b>Joseph Engelmeier</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>MARY WERNIG</b>  |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |  |  |  | 16. SOCIAL SECURITY NO.<br><b>213-26-9785</b>   |  |  |  |
| 17. INFORMANT<br><b>RECORDS-BCH-4940 EASTERN AVENUE, BALTIMORE, MD</b>  |  |  |  | ADDRESS   |  |  |  |
| 18. <b>009.21</b> CAUSE OF DEATH  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)<br><b>Hemorrhagic colitis</b>  |  |  |  | <b>9 hrs</b>  |  |  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  |  |  | <b>2° Chronic Renal failure</b><br><b>years</b>   |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>Congenital heart failure</b>   |  |  |  | <b>1 mos</b>  |  |  |  |
| 19A. DATE OF OPERATION<br><b>0</b>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)             |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |  | 21E. INJURY OCCURRED<br>While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10-23-1969</b> to <b>10-26-69</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>10-26-1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 23A. SIGNATURE<br><b>John Burton</b>  |  |  |  | 23B. DATE SIGNED<br><b>10-26-69</b>   |  | 23C. PHYSICIAN'S NAME (Type)<br><b>JOHN BURTON, MD</b>               |  |
| 23D. ADDRESS<br><b>BCH-4940 EASTERN AVENUE, BALTIMORE, MD.</b>  |  |  |  | 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  |  |  |
| 24B. DATE<br><b>10-29-69</b>  |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>OAK LAWN CEM.</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>7225 EASTERN BLVD, BA. Co., MD.</b>   |  |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 29 1969</b>   |  | 25B. NAME OF REGISTRAR<br><b>Charles E. Taylor</b>   |  | 25C. FUNERAL DIRECTOR<br><b>Charles E. Taylor</b>   |  |  |  |
| 25D. ADDRESS<br><b>6224 EASTERN AVE, BALTO, 21224, MD.</b>  |  |  |  |   |  |  |  |

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# FUNERAL DIRECTOR: IMPORTANT

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|   |                     |  |   |   |   |  |  |
|---|---------------------|--|---|---|---|--|--|
| Y-200<br>BIRTH NO.  |                     | 69 10595   |   | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH  |   | Registered No. 69 10595  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Thomas Ross Yox</i>   |                     |  |   | 2. DATE AND HOUR OF DEATH<br><i>Oct 27, 1969 1:35 A.M.</i>  |   |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><i>48 Maryland General Hospital</i>  |                     |  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Owings Mills</i><br>D. STREET ADDRESS (If rural, give location) <i>10714 Reisterstown Rd</i> |   |  |  |
| 5. SEX<br><i>M</i>  | 6. RACE<br><i>W</i> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><i>Married</i>                             | 8. DATE OF BIRTH<br><i>01-24-00</i>             | 9. AGE (In years last birthday)<br><i>69</i>  | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.                        |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Self-employed</i>   |                     | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Auto-mechanic</i>  |   | 11. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  |
| 13. FATHER'S NAME<br><i>John Yox</i>  |                     |  | 14. MOTHER'S MAIDEN NAME<br><i>Ida Mitchell</i> |   |   |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>NO</i>   |                     |  | 16. SOCIAL SECURITY NO.<br><i>218-07-0894</i>   |   | 17. INFORMANT<br><i>Mrs. Ella Yox</i><br><i>Hospital Records &amp; Family</i> |  |  |
|   |                     |  | ADDRESS<br><i>1210 Hilldale Rd</i>              |   | <i>Balto, Md 21237</i>  |  |  |
| 18. <i>412.31</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION (loss). |                     |  |   | (A) <i>Pulm. cong. + edema</i><br>DUE TO<br>(B) <i>ASHD</i><br>DUE TO<br>(C) _____  |   | INTERVAL BETWEEN ONSET AND DEATH<br><i>2-3 wks</i><br><i>years</i>                 |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                     |  |   |   |   |  |  |
| 19A. DATE OF OPERATION<br><i>2</i>  |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No)<br><i>yes</i>   |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><i>yes</i> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                     | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?  |   |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9/30</i> <i>1969</i> to <i>10/27</i> <i>1969</i> , that (I) (we) last saw the deceased alive on <i>10/27</i> <i>1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.      |                     |  |   |   |   |  |  |
| 23A. SIGNATURE<br><i>Michael Yen</i>  |                     |  |   | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>  |   | 23B. DATE SIGNED<br><i>10/27/69</i>  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><i>MICHAEL YEN M.D.</i>   |                     | 23D. ADDRESS<br><i>827 LINDEN AVE. BALTO.</i>  |   |   |   |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |                     | 24B. DATE<br><i>Oct 30, 1969</i>   |   | 24C. NAME of CEMETERY or CREMATORY<br><i>LAKE View Mem. Park</i>  |   | 24D. LOCATION (City, town, or county) (State)<br><i>Sykesville, Maryland.</i>      |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>OCT 29 1969</i>   |                     | 25B. NAME OF REGISTRAR<br><i>Robert E. Jaber, M.D.</i>   |   | 25C. FUNERAL DIRECTOR<br><i>H. J. Schardt</i>   |   |  |  |
|   |                     |  |   | ADDRESS<br><i>Owings Mills, Md.</i>   |   |  |  |



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IN THIS CASE

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2000 10/15/52

Pattern. card. + evidence  
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Xos

also ed 10/15/52

MICHAEL YEN MD 852 LINDEN AVE. BAY



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

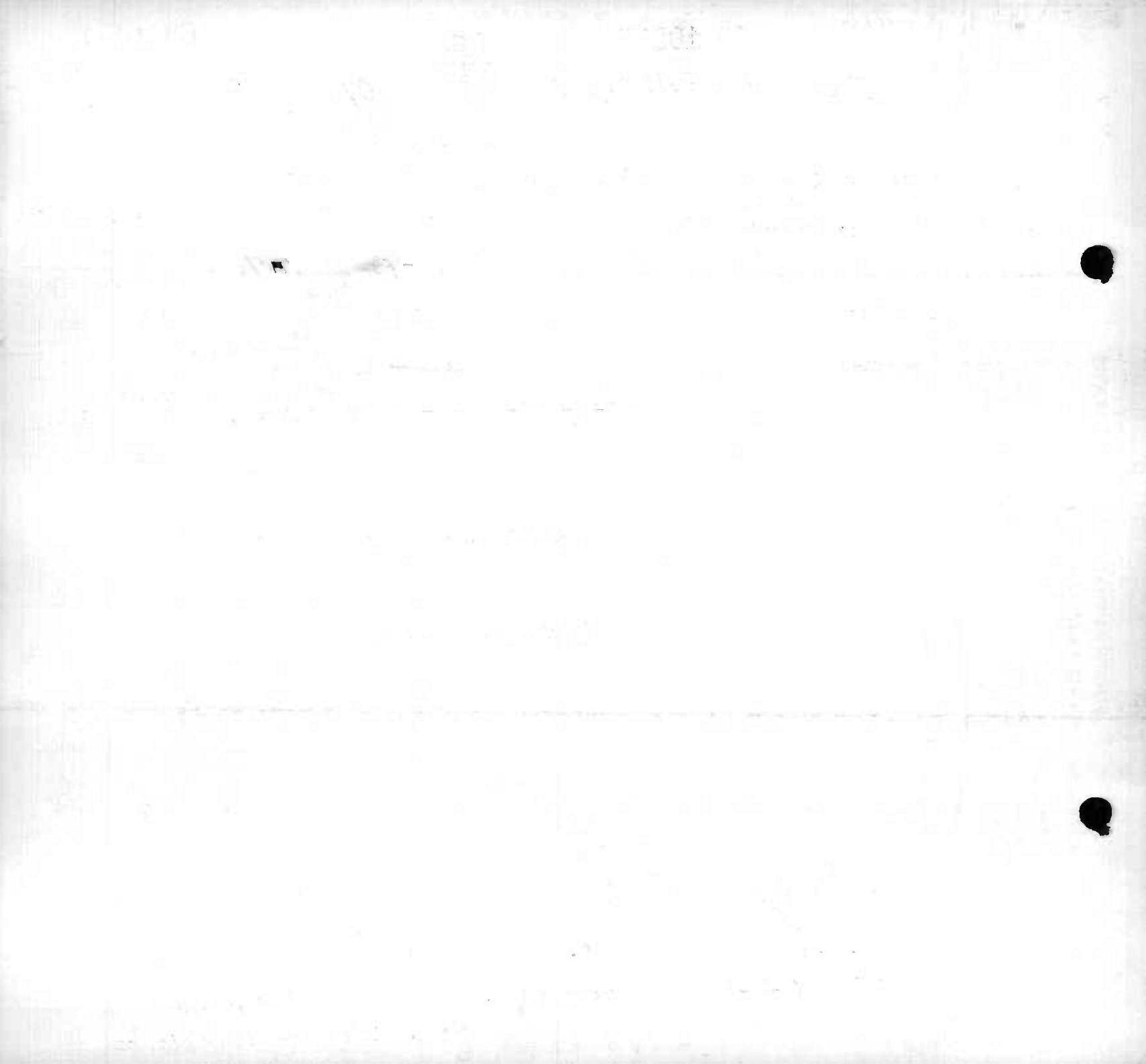
| BALTIMORE CITY HEALTH DEPARTMENT   |              |  |                     | REG. NO. <b>69 10596</b>   |                            |
|--|--------------|--|---------------------|--|----------------------------|
| L-300  |              | 69 10596   |                     | CERTIFICATE OF DEATH   |                            |
| 1. NAME OF DECEASED<br>(Type or Print)   |              | 2. DATE AND HOUR OF DEATH  |                     |  |                            |
| <i>Charles T. Lloyd</i>  |              | <i>Oct 27th 69 6:30 A.M.</i>   |                     |  |                            |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |              | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)                  |                     |  |                            |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |              | A. STATE   |                     | B. COUNTY  |                            |
|  |              | <i>MD.</i>   |                     | <i>1803</i>  |                            |
| <i>00243 W. Lombard St.</i>  |              | C. CITY OR TOWN  |                     | D. INSIDE CITY LIMITS?   |                            |
|  |              | <i>Baltimore</i>   |                     | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |                            |
|  |              | E. STREET AND NUMBER   |                     |  |                            |
|  |              | <i>1243 W. Lombard St.</i>   |                     |  |                            |
| 5. SEX   | 6. RACE      | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                             | 8. DATE OF BIRTH    | 9. AGE (In years last birthday)  | If Under 1 Yr. Months Days |
| <i>Male</i>  | <i>White</i> | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                          | <i>Nov. 23 1890</i> | <i>78</i>  |                            |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |              | 10B. KIND OF BUSINESS OR INDUSTRY  |                     | 11. BIRTHPLACE (State or foreign country)                                |                            |
| <i>Restaurant Man</i>  |              | <i>Restaurant</i>  |                     | <i>Balt. Md.</i>   |                            |
| 13. FATHER'S NAME  |              | 14. MOTHER'S MAIDEN NAME   |                     |  |                            |
| <i>Robert Lloyd</i>  |              | <i>Alfreda ?</i>   |                     |  |                            |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |              | 16. SOCIAL SECURITY NO.  |                     | 17. INFORMANT  |                            |
| <i>No</i>  |              | <i>212-07-9189</i>   |                     | <i>Edith Knott - 1243 W. Lombard St.</i>                                 |                            |
| 18. <i>43791</i>   |              | CAUSE OF DEATH   |                     |  |                            |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |              | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:   |                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |                            |
|  |              | <i>Dehydration</i>   |                     |  |                            |
|  |              | (B) DUE TO, OR AS A CONSEQUENCE OF:  |                     |  |                            |
|  |              | <i>Seiz. Cerebral artery sclerosis</i>   |                     | <i>7 days</i>  |                            |
|  |              | (C) _____  |                     | <i>6 weeks</i>   |                            |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |              |  |                     |  |                            |
| 19A. DATE OF OPERATION   |              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                     | 20A. AUTOPSY? (Yes or No)  |                            |
| <i>No</i>  |              |  |                     | <i>No</i>  |                            |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |              | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |                     | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                            |
| <input type="checkbox"/>   |              |  |                     |  |                            |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |              | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                     | 21F. HOW DID INJURY OCCUR?   |                            |
|  |              |  |                     |  |                            |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9/27/69</i> 19 to <i>10/27/69</i> 19, that (I) (we) last saw the deceased alive on <i>10/27/69</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.  |              |  |                     |  |                            |
| 23A. SIGNATURE <i>S. Munese</i>  |              |  |                     | 23B. DATE SIGNED <i>10/27/69</i>   |                            |
| 23C. PHYSICIAN'S NAME (Type)   |              | 23D. ADDRESS   |                     |  |                            |
| <i>101 S. POPPLETON STREET</i>   |              | <i>BALTIMORE, MD. 21201</i>  |                     |  |                            |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |              | 24B. DATE  |                     | 24C. NAME OF CEMETERY & CREMATORY  |                            |
| <i>Burial</i>  |              | <i>10/30/69</i>  |                     | <i>St. Pauls Cem.</i>  |                            |
| 25A. DATE REC'D BY HEALTH DEPT.  |              | 25B. NAME OF REGISTRAR   |                     | 25C. FUNERAL DIRECTOR  |                            |
| <i>OCT 29 1969</i>   |              | <i>Robert E. Taylor, R.R.</i>  |                     | <i>John J. Lawrence &amp; Son, Inc.</i>                                  |                            |
|  |              |  |                     | <i>27 W. Hollins</i>   |                            |



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

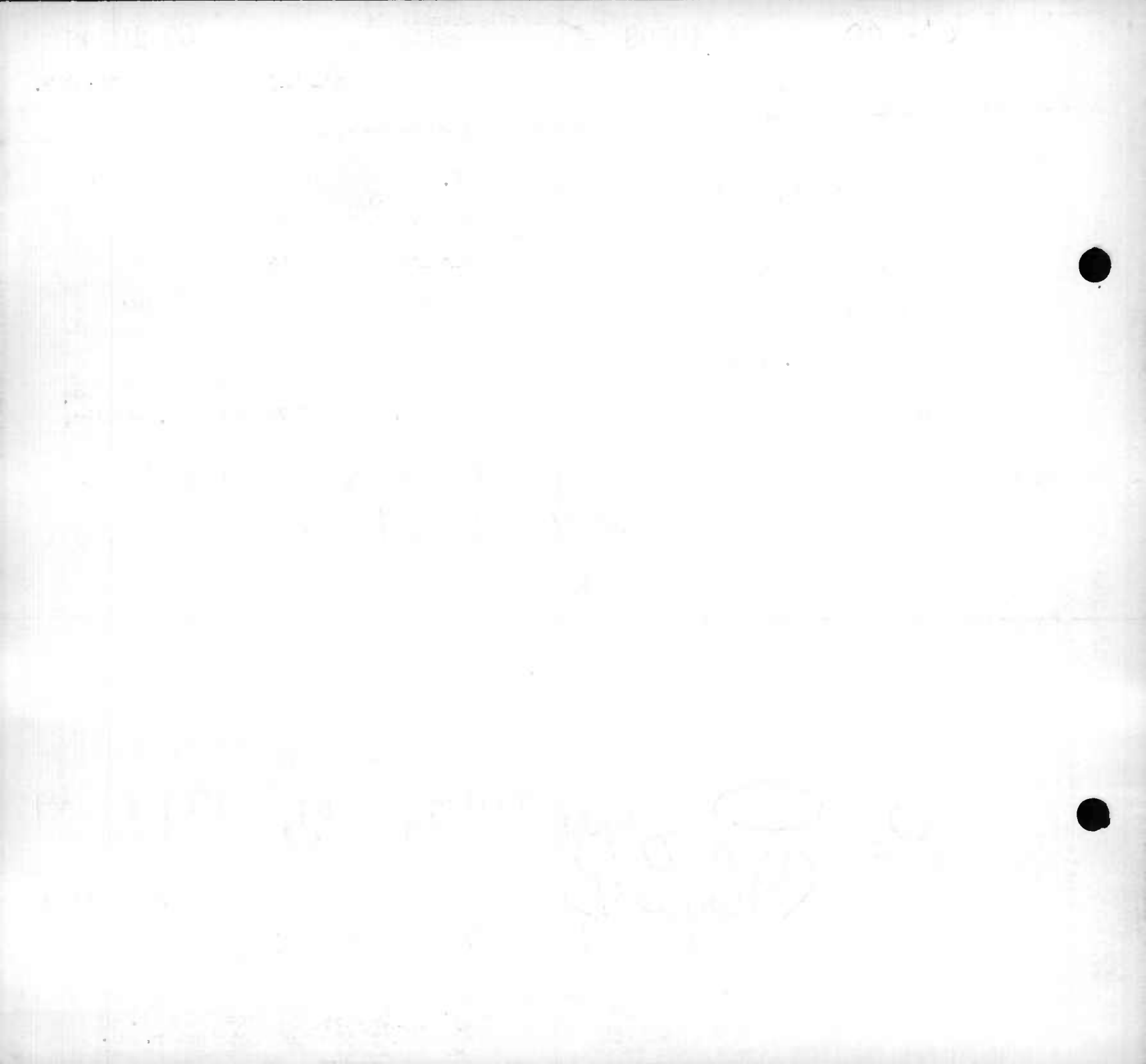
| BIRTH NO.   |                         | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. 69 10597   |  |
|---|-------------------------|---|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>JOHN A. SEALOVER</b>  |                         | 2. DATE AND HOUR OF DEATH<br><b>10/24/69 10:50 P.M.</b>   |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>2610</b>                     |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>BALTIMORE CITY HOSPITAL</b>  |                         | C. CITY OR TOWN<br><b>BALTIMORE</b>   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 1940 Eastern Avenue<br>Baltimore, Maryland 21224  |                         | E. STREET AND NUMBER<br><b>301 S. CLINTON ST 21224 007</b>  |  |   |  |
| 5. SEX<br><b>Male</b>   | 6. RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>7-16-93</b>  | 9. AGE (In years last birthday)<br><b>76</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>   |                         | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                  |  |
| 13. FATHER'S NAME<br><b>Charles</b>   |                         | 14. MOTHER'S MAIDEN NAME<br><b>Mildred Lillian</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |                         | 16. SOCIAL SECURITY NO.<br><b>217-05-5485-A</b>   |  | 17. INFORMANT<br><b>BCH-Records Baltimore, Maryland 21224</b>                                 |  |
| 18. <b>569.9 I</b>  |                         | CAUSE OF DEATH  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><b>PNEUMONIA</b>  |                         | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:   |  |   |  |
| ANTECEDENT CAUSES<br><b>GASTROINTESTINAL BLEEDING</b>   |                         | (B) DUE TO, OR AS A CONSEQUENCE OF:   |  |   |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                         | (C)   |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>DEPRESSION</b>   |                         |   |  |   |  |
| 19A. DATE OF OPERATION<br><b>10/24/69</b>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10/18/69</b> to <b>10/24/69</b> that (I) (we) last saw the deceased alive on <b>10/24/69</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |   |  |   |  |
| 23A. SIGNATURE<br><b>R. K. Maza MD</b>  |                         | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>                             |  | 23B. DATE SIGNED<br><b>10/24/69</b>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>R. K. Maza MD</b>  |                         | 23D. ADDRESS<br><b>4940 Eastern Avenue<br/>BCH- Baltimore, Maryland 21224</b>   |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 24B. DATE<br><b>10-28-69</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>                                |  |
| 24D. LOCATION<br><b>Baltimore, Maryland</b>   |                         | 24E. DATE REC'D BY HEALTH DEPT.<br><b>OCT 29 1969</b>   |  |   |  |
| 24F. NAME OF REGISTRAR<br><b>Robert E. Nader, M.D.</b>  |                         | 24G. FUNERAL DIRECTOR<br><b>John C. Miller Inc-6415 Belair Road</b>   |  |   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

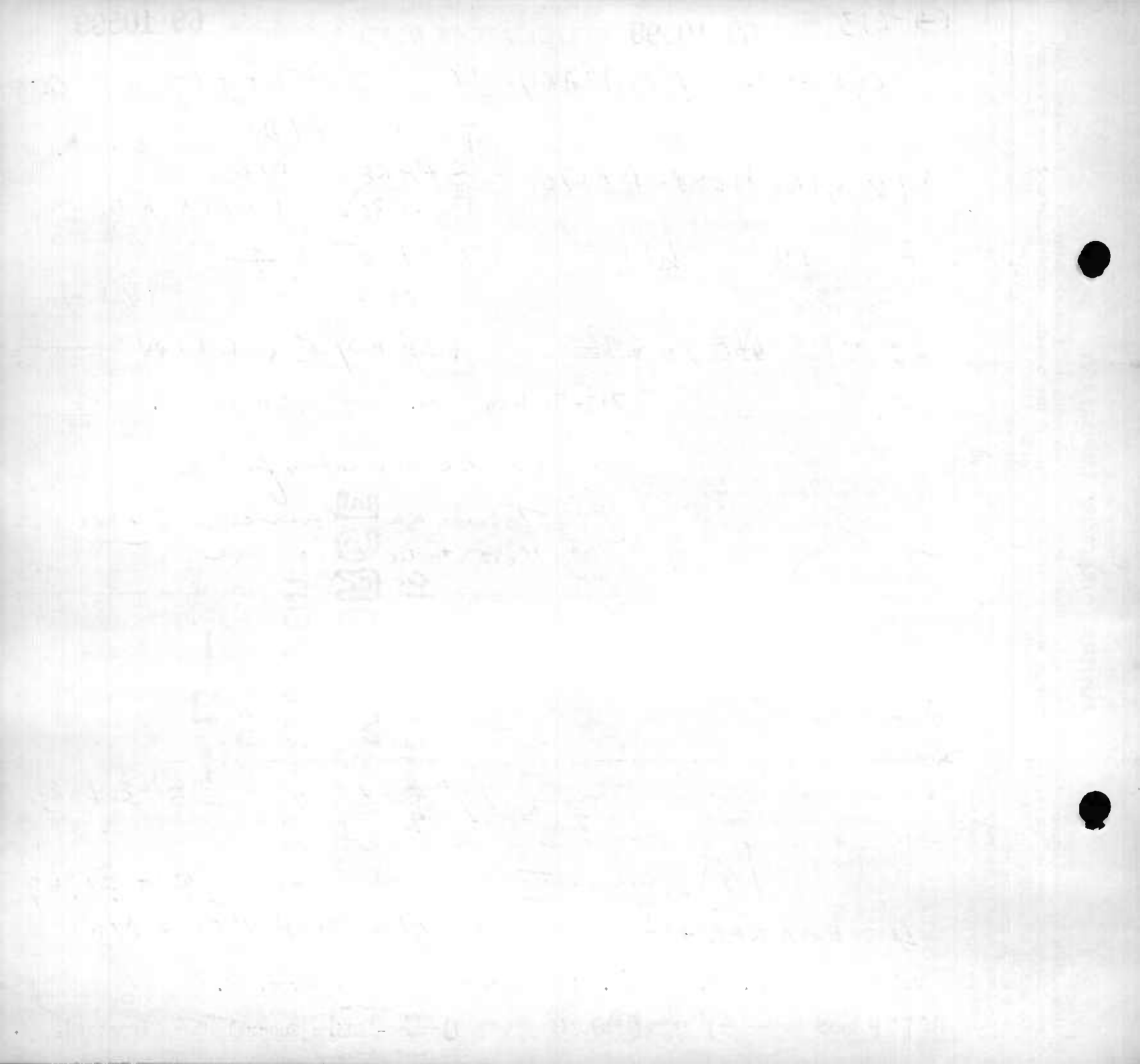
| BALTIMORE CITY HEALTH DEPARTMENT   |  |   |  | REG. NO. <span style="font-size: 2em;">69 10598</span>   |  |
|--|--|---|--|--|--|
| C-600  |  | 69 10598  |  | CERTIFICATE OF DEATH   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <span style="font-size: 1.2em;">NEAL CARR</span>  |  | 2. DATE AND HOUR OF DEATH<br><span style="font-size: 1.2em;">10-24-69</span> <span style="float: right;">12:00 P.</span>                                    |  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  | 4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)   |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><span style="font-size: 1.5em;">37</span> <span style="font-size: 1.2em;">MERCY HOSPITAL</span>  |  | A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">Carroll</span>   |  |  |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |  | C. CITY OR TOWN<br><span style="font-size: 1.2em;">MT. AIRY</span>  |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
|  |  | E. STREET AND NUMBER<br><span style="font-size: 1.2em;">7 FREDERICK AVENUE</span>   |  |  |  |
| 5. SEX<br><span style="font-size: 1.2em;">MALE</span>  | 6. RACE<br><span style="font-size: 1.2em;">WHITE</span>        | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><span style="font-size: 1.2em;">7-31-57</span>   | 9. AGE (In years last birthday)<br><span style="font-size: 1.2em;">12</span>                                       |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><span style="font-size: 1.2em;">student</span>  |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><span style="font-size: 1.2em;">MAINE</span>  | 12. CITIZEN OF WHAT COUNTRY?<br><span style="font-size: 1.2em;">USA</span>   |
| 13. FATHER'S NAME<br><span style="font-size: 1.2em;">KENNETH E. CARR</span>  |  | 14. MOTHER'S MAIDEN NAME<br><span style="font-size: 1.2em;">WILMA GLASS</span>  |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><span style="font-size: 1.2em;">NO</span>  |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><span style="font-size: 1.2em;">Kenneth E. Carr</span> ADDRESS <span style="font-size: 1.2em;">Md. 7 Frederick Ave. Mt Airy,</span> |  |
| 18. CAUSE OF DEATH   |  |   |  |  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  |  |   | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><span style="font-size: 1.5em;">Bronchopneumonia</span> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><span style="font-size: 1.2em;">1 week</span>                      |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |  |   | (B) <span style="font-size: 1.5em;">Medulloblastoma</span><br>DUE TO, OR AS A CONSEQUENCE OF:                  |  | <span style="font-size: 1.2em;">2 YEARS</span>   |
| (C) _____  |  |   |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |   |  |  |  |
| 19A. DATE OF OPERATION<br><span style="font-size: 1.2em;">2</span>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><span style="font-size: 1.2em;">yes</span>  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><span style="font-size: 1.2em;">yes</span> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">17 Aug</span> 1969 to <span style="font-size: 1.2em;">24 Oct</span> 1969 that (I) (we) lost saw the deceased alive on <span style="font-size: 1.2em;">24 Oct</span> 1969 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |   |  |  |  |
| 23A. SIGNATURE<br><span style="font-size: 1.5em;">Edward D. Layne MD</span>  |  |   |  | 23B. DATE SIGNED<br><span style="font-size: 1.2em;">24 Oct 69</span>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><span style="font-size: 1.2em;">Edward D. Layne MD</span>  |  | 23D. ADDRESS<br><span style="font-size: 1.2em;">Mercy Hospital</span>   |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><span style="font-size: 1.2em;">Burial</span>  | 24B. DATE<br><span style="font-size: 1.2em;">10 27 1969</span> | 24C. NAME OF CEMETERY OR CREMATORY<br><span style="font-size: 1.2em;">Saint Marys Cemetery</span>   |  | 24D. LOCATION (City, town, or county) (State)<br><span style="font-size: 1.2em;">Silver Run Maryland</span>  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><span style="font-size: 1.2em;">OCT 29 1969</span>  |  | 25B. NAME OF REGISTRAR<br><span style="font-size: 1.2em;">Robert E. J. J. J.</span>   |  | 25C. FUNERAL DIRECTOR'S ADDRESS<br><span style="font-size: 1.2em;">Thomas D. Fletcher Westminster. Md.</span>  |  |



# FUNERAL DIRECTOR: IMPORTANT

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|  |                        |  |                  |  |                            |  |  |
|--|------------------------|--|------------------|--|----------------------------|--|--|
| G-613  |                        | 69 10599   |                  | BALTIMORE CITY HEALTH DEPT.  |                            | Registered No. 69 10599  |  |
| BIRTH NO.  |                        | M.E. CASE NO.  |                  | 1. NAME OF DECEASED<br>(Type or Print)   |                            | 2. DATE AND HOUR OF DEATH  |  |
|  |                        |  |                  | GRIFFITH, Mrs. MARY. M.  |                            | 26 <sup>th</sup> Oct 69 08:00 AM                                     |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |                        |  |                  | 4. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) |                            |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  |                        |  |                  | A. STATE B. COUNTY   |                            |  |  |
| MD. GEN. HOSP. BALTO.  |                        |  |                  | BALTO. CO. 5300  |                            |  |  |
|  |                        |  |                  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)                |                            |  |  |
|  |                        |  |                  | SPARKS, MD.  |                            |  |  |
|  |                        |  |                  | D. STREET ADDRESS (If rural, give location)  |                            |  |  |
|  |                        |  |                  | Box 302 FALLS RD.  |                            |  |  |
| 5. SEX   | 6. RACE                | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)                                   | 8. DATE OF BIRTH | 9. AGE (In years last birthday)  | If Under 1 Yr. Months Days |  |  |
| F  | W                      | W.   | 7/18/85          | 84   |                            |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                        | 10B. KIND OF BUSINESS OR INDUSTRY  |                  | 11. BIRTHPLACE (State or foreign country)  |                            | 12. CITIZEN OF WHAT COUNTRY?   |  |
| Housewife  |                        |  |                  | MD.  |                            | USA  |  |
| 13. FATHER'S NAME  |                        |  |                  | 14. MOTHER'S MAIDEN NAME   |                            |  |  |
| JAMES NAYLOR   |                        |  |                  | MARY CURTIN  |                            |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |                        | 16. SOCIAL SECURITY NO.  |                  | 17. INFORMANT ADDRESS  |                            |  |  |
| NO   |                        | 217-30-1854  |                  | Mrs. Mary Tegeler Falls Rd. Sparks   |                            |  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)   |                        |  |                  | CAUSE OF DEATH   |                            |  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH   |                        |  |                  | (A) Cardiorespiratory failure  |                            |  |  |
| ANTECEDENT CAUSES  |                        |  |                  | (B) Terminal Cancer  |                            |  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                        |  |                  | (C) Metastatic Carcinoma COLON   |                            |  |  |
| II   |                        |  |                  | INTERVAL BETWEEN ONSET AND DEATH   |                            |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                        |  |                  | 24 hrs   |                            |  |  |
| 19A. DATE OF OPERATION   |                        | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                  | 20A. AUTOPSY? (Yes or No)  |                            | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
|  |                        |  |                  | NO   |                            |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                        | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |                  | 21C. WHERE DID INJURY OCCUR?   |                            | (If in Baltimore City, give exact location)                          |  |
|  |                        |  |                  |  |                            |  |  |
| 21D. TIME OF INJURY (APPROX.)  |                        | 21E. INJURY OCCURRED   |                  | 21F. HOW DID INJURY OCCUR?   |                            |  |  |
|  |                        | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |                  |  |                            |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 1 <sup>st</sup> Oct 1969 to 25 <sup>th</sup> Oct 1969, that (I) (we) last saw the deceased alive on 25 <sup>th</sup> Oct 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                        |  |                  |  |                            |  |  |
| 23A. SIGNATURE   |                        |  |                  | 23B. DATE SIGNED   |                            |  |  |
| A. S. RANGANATH  |                        |  |                  | Oct 26 <sup>th</sup> 69  |                            |  |  |
| 23C. PHYSICIAN'S NAME (Type)   |                        | 23D. ADDRESS   |                  |  |                            |  |  |
| A. S. RANGANATH  |                        | MD. MD. GEN. HOSP. BALTO. MD.  |                  |  |                            |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   | 24B. DATE              | 24C. NAME of CEMETERY or CREMATORY   |                  | 24D. LOCATION (City, town, or county)  |                            | (State)  |  |
| Burial   | Oct. 30, 1969          | Mt. Zion Cemetery  |                  | Upperco, Md.   |                            |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.  | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR  |                  |  |                            | ADDRESS  |  |
| OCT 29 1969  | Robert E. Taylor       | Opton - Elaine Funeral Home  |                  | Hampstead, Md.   |                            |  |  |

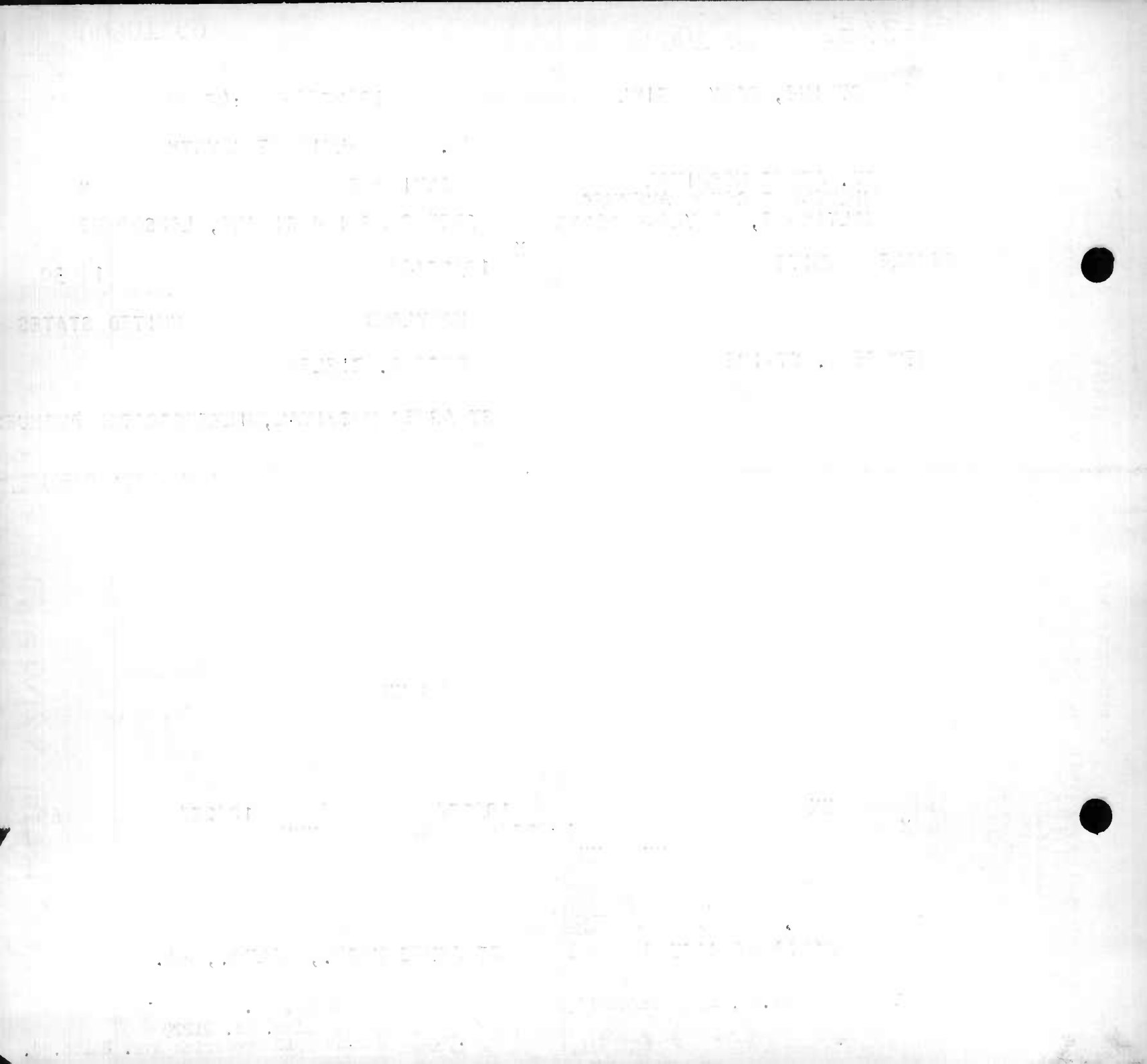




# FUNERAL DIRECTOR: IMPORTANT

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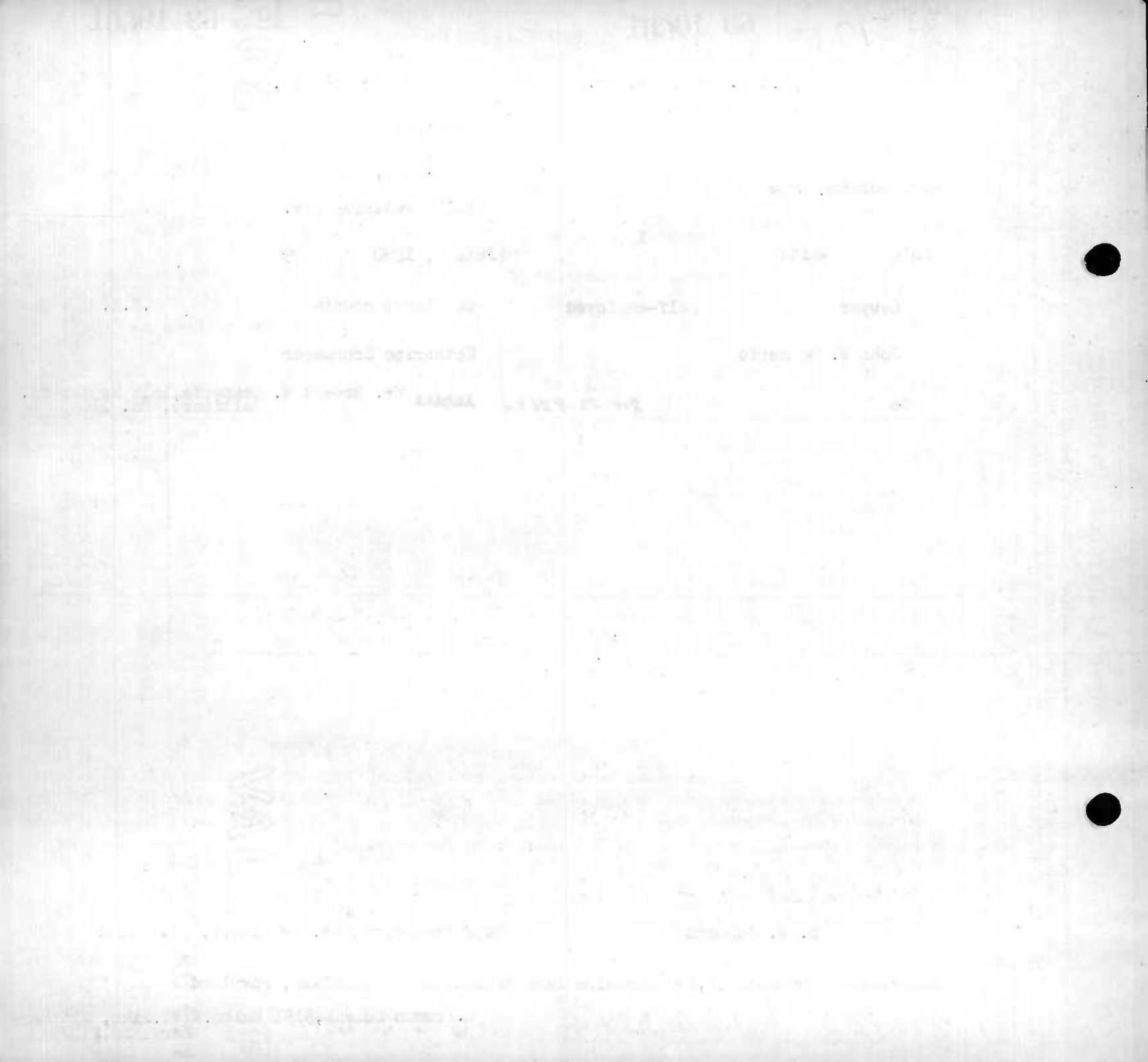
|  |  |  |  |
|--|--|--|--|
| <div style="display: flex; justify-content: space-between;"> <span>S-365 69 19896</span> <span>69 10600</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>  |  | REG. NO. <span style="font-size: 2em;">69 10600</span>   |  |
| BIRTH NO. <span style="font-size: 1.5em;">69-19896</span>  |  | 2. DATE AND HOUR OF DEATH<br><div style="display: flex; justify-content: space-between;"> <span>10/25/69</span> <span>8:45 PM</span> </div>  |  |
| 1. NAME OF DECEASED<br>(Type or Print)<br><div style="text-align: center; font-size: 1.2em;">STRINE, BABY GIRL Kerri Ann</div>   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <span style="font-size: 1.2em;">MD.</span> B. COUNTY <span style="font-size: 1.2em;">BALTIMORE COUNTY</span> <span style="float: right; font-size: 1.5em;">5300</span> |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><div style="font-size: 1.5em;">40</div> <div style="text-align: center; font-size: 1.2em;">ST. AGNES HOSPITAL<br/>WILKENS &amp; CATON AVENUES<br/>BALTIMORE, MARYLAND 21229</div>   |  | C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span><br>D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 5. SEX <span style="font-size: 1.2em;">FEMALE</span>   |  | 6. RACE <span style="font-size: 1.2em;">WHITE</span>   |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH <span style="font-size: 1.2em;">10/25/69</span>   |  |
| 9. AGE (In years last birthday)<br><div style="display: flex; justify-content: space-between;"> <span>10</span> <span>25</span> <span>69</span> </div>   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  |
| 11. BIRTHPLACE (State or foreign country)<br><span style="font-size: 1.2em;">MARYLAND</span>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><span style="font-size: 1.2em;">UNITED STATES</span>   |  |
| 13. FATHER'S NAME<br><span style="font-size: 1.2em;">GEORGE D. STRINE</span>   |  | 14. MOTHER'S MAIDEN NAME<br><span style="font-size: 1.2em;">ROSE A. ZIELER</span>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT<br><span style="font-size: 1.2em;">ST AGNES HOSPITAL, WILKENS &amp; CATON AVENUES</span>   |  | ADDRESS  |  |
| 18. <span style="font-size: 1.5em;">726.9 I</span> CAUSE OF DEATH<br><div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p style="text-align: center; font-weight: bold;">ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p style="text-align: center; font-weight: bold;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p> </div> <div style="width: 15%;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p style="font-size: 1.5em;">1 hour</p> </div> </div> |  |  |  |
| 19A. DATE OF OPERATION   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20A. AUTOPSY? (Yes or No)<br><span style="font-size: 1.2em;">NO XX</span>  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |  |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that <del>XX</del> (this hospital) attended the deceased from <span style="font-size: 1.2em;">10/25/1969</span> to <span style="font-size: 1.2em;">10/25/1969</span> that <del>X</del> (we) last saw the deceased alive on <span style="font-size: 1.2em;">10/25/1969</span> and that <del>in</del> <span style="font-size: 1.2em;">XXX</span> (our) opinion death occurred on the date and hour and from the causes stated above. <del>XX</del> (We) <del>(did)</del> (did not) view the body after death.  |  |  |  |
| 23A. SIGNATURE<br><div style="font-size: 1.5em;">        JORGE GARCIA     </div>   |  | 23B. DATE SIGNED<br><span style="font-size: 1.5em;">10-27-69</span>  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><span style="font-size: 1.2em;">Jorge Garcia</span><br><span style="font-size: 1.2em;">MARIA DE CASTRO MD</span>   |  | 23D. ADDRESS<br><span style="font-size: 1.2em;">ST AGNES HOSP., BALTO., MD.</span>   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><span style="font-size: 1.2em;">Burial</span>  |  | 24B. DATE<br><span style="font-size: 1.2em;">Oct. 28, 1969</span>  |  |
| 24C. NAME OF CEMETERY OR CREMATORY<br><span style="font-size: 1.2em;">Meadowridge</span>   |  | 24D. LOCATION (City, town, or county) (State)<br><span style="font-size: 1.2em;">Elkridge, Md.</span>  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><span style="font-size: 1.5em;">OCT 29 1969</span>  |  | 25B. NAME OF REGISTRAR<br><span style="font-size: 1.2em;">G. E. Schwab</span>  |  |
| 25C. FUNERAL DIRECTOR<br><span style="font-size: 1.2em;">Balto. Md. 21229</span>   |  | ADDRESS<br><span style="font-size: 1.2em;">3512 Frederick Ave. Balto. Md.</span>   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| <div style="display: flex; justify-content: space-between;"> <span style="font-size: 2em;">S-510</span> <span>69 10601</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <div style="display: flex; justify-content: space-between;"> <span>BIRTH NO.</span> <span>CERTIFICATE OF DEATH</span> <span>REG. NO. 69 10601</span> </div>  |  |   |   |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>August W. Schnepfe, Sr.</b>   |  |   | 2. DATE AND HOUR OF DEATH<br><b>October 26, 1969</b> <span style="float: right;"><b>1130 A M.</b></span>  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Hood Nursing Home</b>   |  |   | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>2008</b>   |  |  |
| 5. SEX <b>Male</b> 6. RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |   | 8. DATE OF BIRTH <b>June 3, 1880</b> 9. AGE (In years last birthday) <b>89</b>  |  | 10. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Lawyer</b>  |  |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Self-employed</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore county</b>                               |
| 13. FATHER'S NAME<br><b>John W. Schnepfe</b>  |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Katherine Schnaeger</b>  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>214-38-9268A</b>  |   | 17. INFORMANT ADDRESS<br><b>Mr. Robert W. Schnepfe, 1811 Reuter Rd. Baltimore, Md. 21093</b> |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Coronary occlusion</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Cardio Vascular Disease</b> |  |   | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>Coronary occlusion</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>Cardio Vascular Disease</b><br>(C) <b>Myocardial Infarction</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b><br><b>9 years</b><br><b>10 years</b> |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>Left Leg Gangrene Amputation 9/24/69</b>   |  |   |   |  |  |
| 19A. DATE OF OPERATION<br><b>9/24/69</b>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Left Leg Gangrene</b>                              |   | 20A. AUTOPSY? (Yes or No)<br><b>No</b>   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                     |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX.)  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>1/28 1960</b> to <b>10/24/69</b> 19 <b>69</b><br>that (I) (we) lost saw the deceased alive on <b>10/20 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |  |   |   |  |  |
| 23A. SIGNATURE<br><b>E. W. Johnson</b>  |  |   |   | 23B. DATE SIGNED<br><b>10/27/69</b>  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>E. W. Johnson</b>  |  | 23D. ADDRESS<br><b>3432 Frederick Ave. Baltimore, Md. 21229</b>   |   |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Entombment</b>   |  | 24B. DATE<br><b>October 29, 69</b>  |   | 24C. NAME OF CEMETERY or CREMATORY<br><b>Lorraine Park Mausoleum</b>                         |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Woodlawn, Maryland</b>  |  |   |   |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 29 1969</b>   |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher, Jr.</b>  |   | 25C. FUNERAL DIRECTOR<br><b>G. Truman Schrab</b>   |  |
|   |  |   |   | ADDRESS<br><b>5151 Balto. Natl. Pike, Baltimore Maryland, 21229</b>                          |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                                    |  |  |
|---|------------------------------------|--|--|
| <p><b>1. NAME OF DECEASED</b> <b>MOTTER, JOHN WILLIAM</b></p> <p>(Type or Print)</p>  |                                    | <p><b>2. DATE AND HOUR OF DEATH</b></p> <p>OCTOBER 25, 1969 6:25 A.M.</p>  |  |
| <p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p>ST AGNES HOSPITAL<br/>CATON &amp; WILKENS AVENUES<br/>BALTIMORE, MARYLAND 21229</p>  |                                    | <p><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution, residence before admission)</p> <p>A. STATE MARYLAND B. COUNTY HANOVER CO. 20794 6300</p> <p>C. CITY OR TOWN JESSUP D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>E. STREET AND NUMBER BOX 297</p> |  |
| <p><b>5. SEX</b></p> <p>MALE</p>  | <p><b>6. RACE</b></p> <p>WHITE</p> | <p><b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>   | <p><b>8. DATE OF BIRTH</b></p> <p>03/20/98</p> |
| <p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)</p> <p>GROOM</p>  |                                    | <p><b>10B. KIND OF BUSINESS OR INDUSTRY</b></p> <p>Race Horses</p>   |  |
| <p><b>11. BIRTHPLACE</b> (State or foreign country)</p> <p>MISSISSIPPI</p>  |                                    | <p><b>12. CITIZEN OF WHAT COUNTRY?</b></p> <p>U.S.A.</p>   |  |
| <p><b>13. FATHER'S NAME</b></p> <p>Albert Lee Mooter</p>  |                                    | <p><b>14. MOTHER'S MAIDEN NAME</b></p> <p>Ethel ?</p>  |  |
| <p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)</p> <p>NO</p>  |                                    | <p><b>16. SOCIAL SECURITY NO.</b></p> <p>263-48-9278</p>   |  |
| <p><b>17. INFORMANT</b></p> <p>WILKENS AVES, BALTO MD 21229</p>   |                                    | <p><b>ADDRESS</b></p> <p>ST AGNES HOSPITAL RECORDS CATON &amp;</p>   |  |
| <p><b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b></p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>410.91</p>  |                                    | <p><b>CAUSE OF DEATH</b></p> <p>Acute Heart Failure -</p>  |  |
| <p><b>ANTECEDENT CAUSES</b></p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>  |                                    | <p><b>(A) IMMEDIATE CAUSE</b></p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> <p>Acute Myocardial MI</p>  |  |
| <p><b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b></p> <p>A. SEVERE</p>  |                                    | <p><b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b></p>  |  |
| <p><b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b></p> <p>The pt had a pre existing heart condition in 1969 for heart attack</p>   |                                    |  |  |
| <p><b>19A. DATE OF OPERATION</b></p>  |                                    | <p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>   |  |
| <p><b>20A. AUTOPSY?</b> (Yes or No)</p> <p>YES</p>  |                                    | <p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>   |  |
| <p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)</p>   |                                    | <p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg, etc.)</p>  |  |
| <p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>  |                                    | <p><b>21D. TIME OF INJURY</b> (Approx.)</p>  |  |
| <p><b>21E. INJURY OCCURRED</b></p> <p>White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/></p>   |                                    | <p><b>21F. HOW DID INJURY OCCUR?</b></p>   |  |
| <p><b>22. I certify that (X) (this hospital) attended the deceased from OCTOBER 6 19 69 to OCTOBER 25 19 69 that (X) (we) last saw the deceased alive on OCTOBER 25 19 69 and that (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.</b></p> |                                    |  |  |
| <p><b>23A. SIGNATURE</b></p> <p>Alexander Mejia</p>   |                                    | <p><b>23B. DATE SIGNED</b></p>   |  |
| <p><b>23C. PHYSICIAN'S NAME</b> (Type)</p> <p>ALEXANDER MEJIA MD</p>  |                                    | <p><b>23D. ADDRESS</b></p> <p>St Agnes Hospital Caton &amp; Wilkens Aves.</p>  |  |
| <p><b>24A. BURIAL CREMATION, REMOVAL (Specify)</b></p> <p>Burial</p>  |                                    | <p><b>24B. DATE</b></p> <p>28 OCT 69</p>   |  |
| <p><b>24C. NAME of CEMETERY or CREMATORY</b></p> <p>Lorraine Cemetery</p>   |                                    | <p><b>24D. LOCATION</b> (City, town, or county) (State)</p> <p>Baltimore, Maryland</p>   |  |
| <p><b>25A. DATE REC'D BY HEALTH DEPT.</b></p> <p>OCT 29 1969</p>  |                                    | <p><b>25B. NAME OF REGISTRAR</b></p> <p>Robert E. Fisher, M.D.</p>   |  |
| <p><b>25C. FUNERAL DIRECTOR</b></p> <p>J. E. Lowell</p>   |                                    | <p><b>ADDRESS</b></p> <p>4611 Park Heights Ave.</p>  |  |

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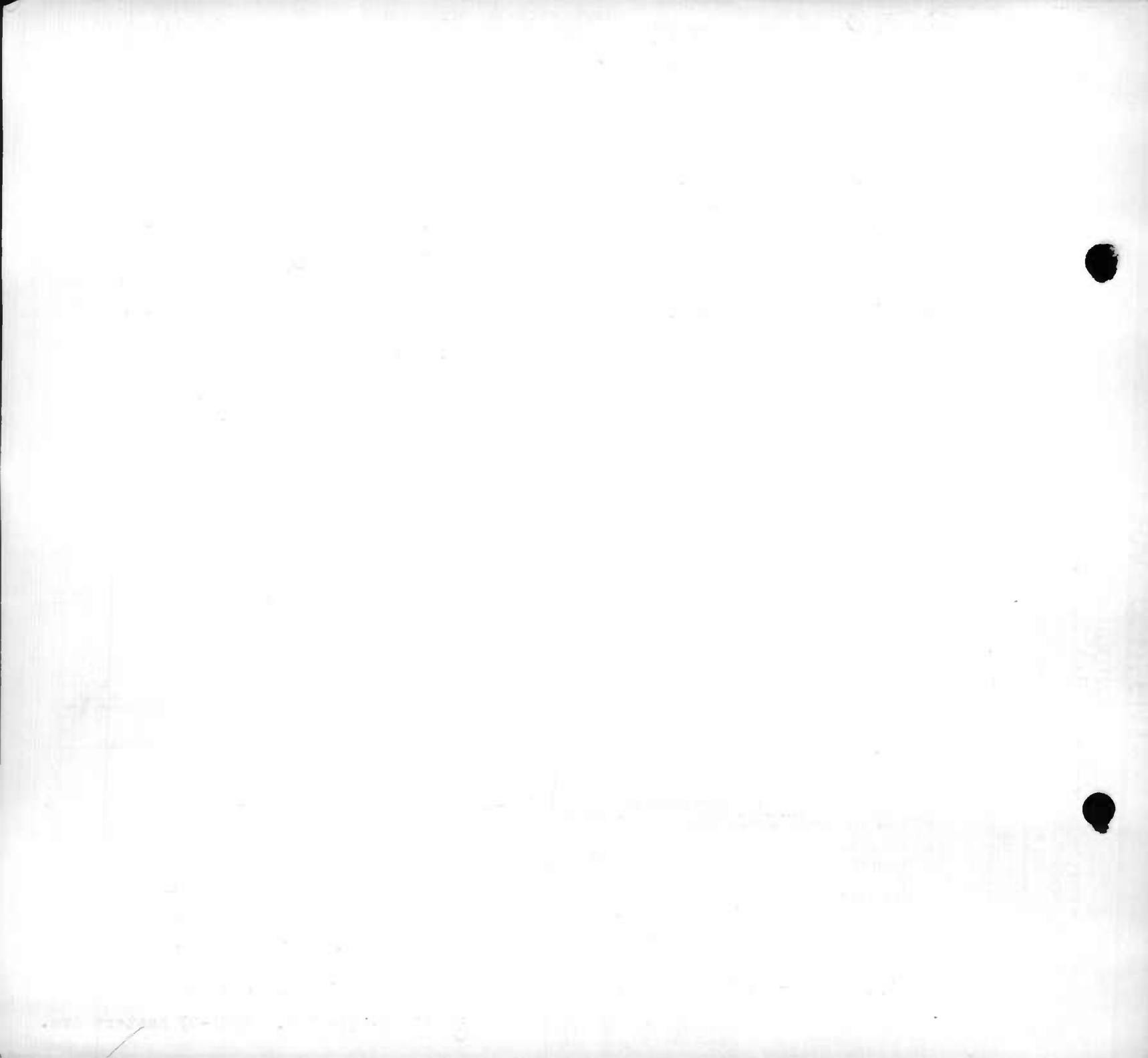
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# FUNERAL DIRECTOR: IMPORTANT

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| BALTIMORE CITY HEALTH DEPARTMENT  |  |   |  | REG. NO. <b>69 10603</b>  |  |
|---|--|---|--|---|--|
| <b>3-340</b><br><b>69 10603</b>   |  | <b>CERTIFICATE OF DEATH</b>   |  |   |  |
| <b>BIRTH NO.</b><br><b>1. NAME OF DECEASED</b><br>(Type or Print) <b>ANNA MAY STEEL</b>   |  | <b>2. DATE AND HOUR OF DEATH</b><br><b>7:30 P.M. 10/27/69</b>   |  |   |  |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br>FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE CITY HOSPITALS</b><br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>4940 EASTERN AVE.</b><br><b>BALTIMORE, MD. 21224</b>  |  | <b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution; residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>2609</b> |  |   |  |
| <b>5. SEX</b><br><b>FEMALE</b>  |  | <b>6. RACE</b><br><b>WHITE</b>  |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  | <b>10B. KIND OF BUSINESS OR INDUSTRY</b><br><b>Own Home</b>   |  | <b>8. DATE OF BIRTH</b><br><b>11-12-88</b>  |  |
| <b>13. FATHER'S NAME</b><br><b>Harry Wolf</b>   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Bertha</b>  |  | <b>9. AGE</b> (In years last birthday)<br><b>80</b>   |  |
| <b>15. Was Deceased Ever in U. S. Armed Forces?</b><br>(Yes, no or unknown) (If yes, give war or dates of service)  |  | <b>16. SOCIAL SECURITY NO.</b>  |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>MARYLAND</b>   |  |
| <b>17. INFORMANT</b><br><b>4940 EASTERN AVE.</b>  |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>U.S.A.</b>  |  |   |  |
| <b>18. CAUSE OF DEATH</b><br><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  | <b>(A) IMMEDIATE CAUSE</b><br><b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF:   |  | <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b><br><b>20 MINOS - 45 MIN.</b>  |  |
| <b>(B) Hypertensive Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF:   |  | <b>(C)</b>  |  | <b>15 YEARS</b>   |  |
| <b>II</b><br><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>  |  |   |  |   |  |
| <b>19A. DATE OF OPERATION</b><br><b>10-27-69</b>  |  | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>   |  | <b>20A. AUTOPSY? (Yes or No)</b><br><b>NO</b>   |  |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)  |  | <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)   |  |
| <b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)  |  | <b>21E. INJURY OCCURRED</b><br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                  |  | <b>21F. HOW DID INJURY OCCUR?</b>   |  |
| <b>22. I certify that (I) (this hospital) attended the deceased from 7-6-69 to 10-27-69 that (I) (we) last saw the deceased alive on 10-27-69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>  |  |   |  |   |  |
| <b>23A. SIGNATURE</b><br><b>Arnold Levinson, M.D.</b>   |  |   |  | <b>23B. DATE SIGNED</b><br><b>10-27-69</b>  |  |
| <b>23C. PHYSICIAN'S NAME</b> (Type)<br><b>ARNOLD LEVINSON MD.</b>   |  | <b>23D. ADDRESS</b><br><b>BALTIMORE CITY HOSPITALS</b><br><b>4940 EASTERN AVE. BALTIMORE, MD. 21224</b>   |  |   |  |
| <b>24A. BURIAL CREMATION, REMOVAL (Specify)</b><br><b>Burial</b>  |  | <b>24B. DATE</b><br><b>10-30-1969</b>   |  | <b>24C. NAME OF CEMETERY OR CREMATORY</b><br><b>Parkwood</b>  |  |
| <b>24D. LOCATION</b> (City, town, or county) (State)<br><b>Baltimore, Maryland</b>  |  | <b>25A. DATE REC'D BY HEALTH DEPT.</b><br><b>OCT 29 1969</b>  |  |   |  |
| <b>25B. NAME OF REGISTRAR</b>   |  | <b>25C. FUNERAL DIRECTOR</b><br><b>Lilly &amp; Zeiler Inc. 1901-07 Eastern Ave.</b>   |  |   |  |





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

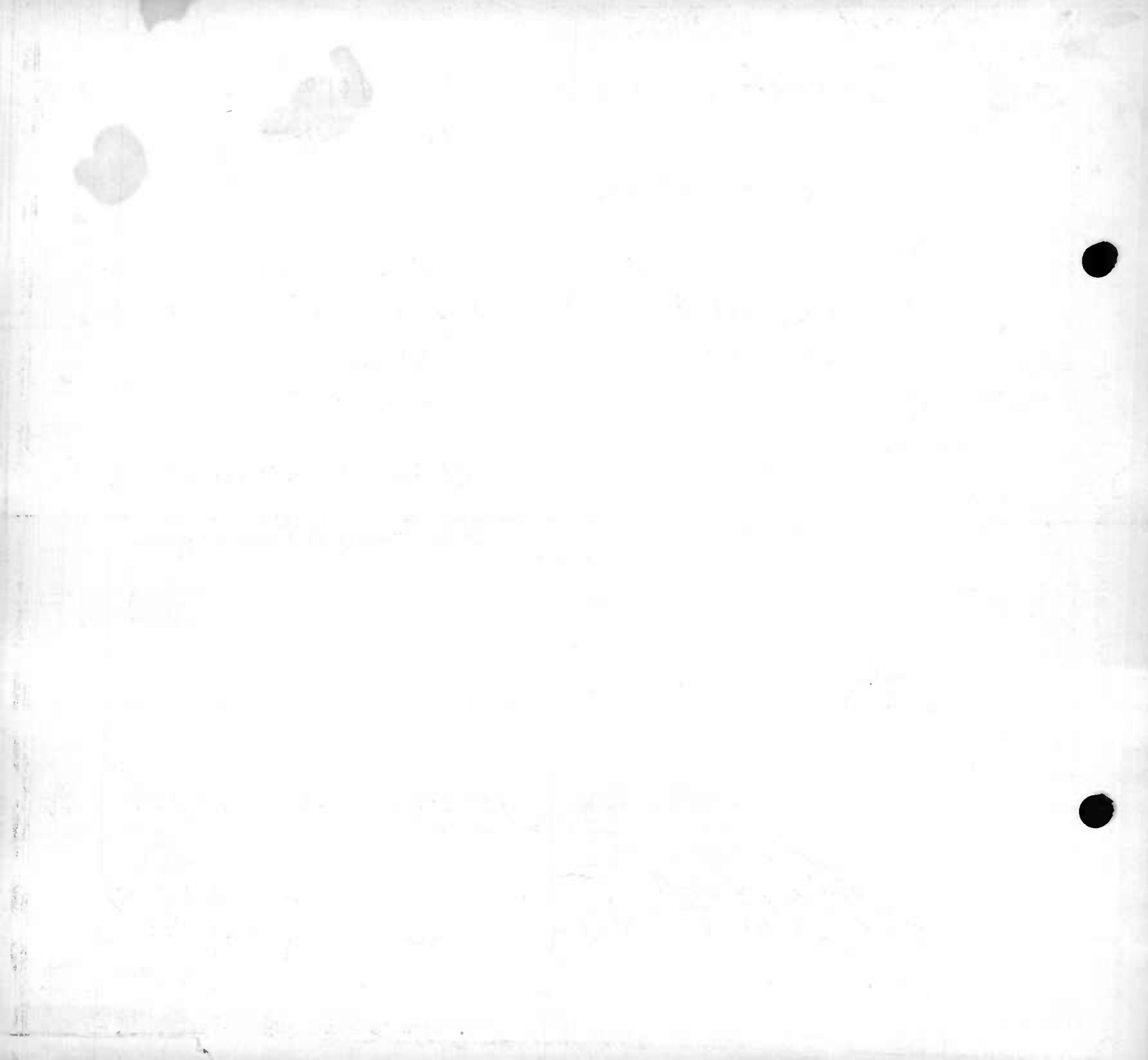
| F-652 69 10604 BALTIMORE CITY HEALTH DEPARTMENT  |         |  |   | REG. NO. 69 10604  |  |
|--|---------|--|---|--|--|
| BIRTH NO.  |         | 1. NAME OF DECEASED<br>(Type or Print)   |   | 2. DATE AND HOUR OF DEATH  |  |
|  |         | Florence M. Frank  |   | October 27, 1969   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |         |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><br>00   |         |  | A. STATE B. COUNTY<br>3302 Cedarhurst Road 2702                                       |  |  |
| 3302 Cedarhurst Road 14  |         |  | C. CITY OR TOWN<br>Baltimore Md.  |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
|  |         |  | E. STREET AND NUMBER  |  |  |
| 5. SEX   | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>               | 8. DATE OF BIRTH  | 9. AGE (In years last birthday)  | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.                             |
| Female   | White   | WIDOWED <input checked="" type="checkbox"/> * DIVORCED <input type="checkbox"/>          | Jan. 1, 1891  | 78   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |         | 10B. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)                                |  |
| none   |         | none   |   | Baltimore Md.  |  |
| 13. FATHER'S NAME<br>Thomas D. Frank   |         |  | 12. CITIZEN OF WHAT COUNTRY?  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |         |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |
| no no  |         |  | 216-12-2248   |  | A. Mrs. Margaret Frederick, 3302 Cedarhurst Rd                                     |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   |         |  | CAUSE OF DEATH  |  |  |
| 410.9 I  |         |  | Cerebral occlusion  |  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |         |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) Antecedent C. V. D.<br>(C) |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |         |  | Septicemic disease  |  |  |
| 19A. DATE OF OPERATION   |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No)  |  |
| 6  |         |  |   |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
|  |         |  |   |  |  |
| 21D. TIME OF INJURY (APPROX.)  |         | 21E. INJURY OCCURRED   |   | 21F. HOW DID INJURY OCCUR?   |  |
|  |         | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |   |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 1956 to October 27 1969, that (I) (we) last saw the deceased alive on Oct 27 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. |         |  |   |  |  |
| 23A. SIGNATURE   |         |  |   | 23B. DATE SIGNED   |  |
| J. Henry Haase M.D.  |         |  |   | 10/29/69   |  |
| 23C. PHYSICIAN'S NAME (Type)   |         | 23D. ADDRESS   |   |  |  |
| J. Henry Haase M.D.  |         | 2500 S. Calverton Rd. Baltimore 21214  |   |  |  |
| 24A. BURIAL CREMATION REMOVAL (Specify)  |         | 24B. DATE  |   | 24C. NAME OF CEMETERY or CREMATORY                                       |  |
| Burial   |         | Oct. 30/69   |   | Oak Lawn Cem.  |  |
| 25A. DATE REC'D BY HEALTH DEPT.  |         | 25B. NAME OF REGISTRAR   |   | 25C. FUNERAL DIRECTOR  |  |
| OCT 29 1969  |         | Robert E. Fisher M.D.  |   | Philip H. Hargis Sons 2024 Orleans St.                                   |  |
|  |         |  |   | ADDRESS  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

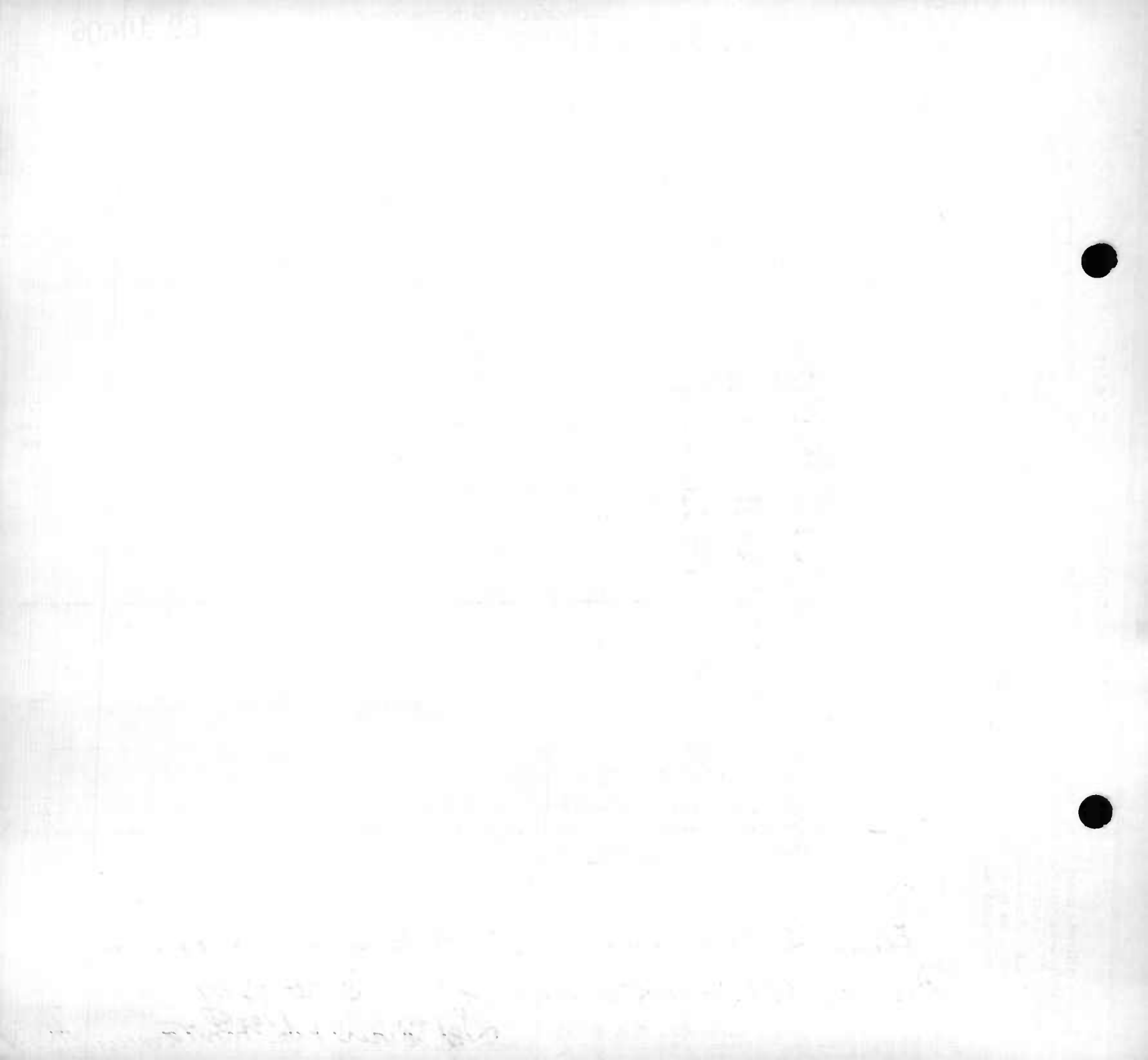
|  |  |   |   |
|--|--|---|---|
| <div style="display: flex; justify-content: space-between;"> <span>D-264</span> <span>69 10605</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>   |  | REG. NO. <span style="font-size: 1.2em;">69 10605</span>  |   |
| BIRTH NO. <span style="font-size: 1.2em;">1</span>   |  | 2. DATE AND HOUR OF DEATH<br><div style="display: flex; justify-content: space-between;"> <span>10/25/69</span> <span>2:15 P.M.</span> </div>   |   |
| 1. NAME OF DECEASED<br>(Type or Print) <span style="font-size: 1.2em;">De Carlo, Canio Vincent</span>  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>A. STATE <span style="font-size: 1.2em;">Prince Georges</span>   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><span style="font-size: 1.2em;">38 University Hosp.</span>  |  | 5. CITY OR TOWN <span style="font-size: 1.2em;">Greenbelt</span><br>D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <span style="font-size: 1.2em;">6400</span><br><span style="font-size: 1.2em;">Md.</span> |   |
| 5. SEX <span style="font-size: 1.2em;">M</span>  | 6. RACE <span style="font-size: 1.2em;">W</span> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <span style="font-size: 1.2em;">4/12/92</span> |
| 9. AGE (In years last birthday) <span style="font-size: 1.2em;">77</span>  |  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.   |   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><span style="font-size: 1.2em;">Painter (Retired) Contractor</span>   |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><span style="font-size: 1.2em;">Massachusetts</span>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><span style="font-size: 1.2em;">Massachusetts</span>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><span style="font-size: 1.2em;">U.S.A.</span>   |   |
| 13. FATHER'S NAME<br><span style="font-size: 1.2em;">Pasquale DE Carlo</span>  |  | 14. MOTHER'S MAIDEN NAME<br><span style="font-size: 1.2em;">Rosa</span>   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><span style="font-size: 1.2em;">No</span>  |  | 16. SOCIAL SECURITY NO.<br><span style="font-size: 1.2em;">214-26-3784</span>   |   |
| 17. INFORMANT<br><span style="font-size: 1.2em;">Canio P. De Carlo District 4th Md.</span>   |  | ADDRESS   |   |
| 18. <span style="font-size: 1.2em;">44101</span> CAUSE OF DEATH  |  |   |   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><span style="font-size: 1.2em;">Ruptured abdominal aorta</span><br>(B) <span style="font-size: 1.2em;">dissentering aortic</span><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C)                                 |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |   |   |
| 19A. DATE OF OPERATION<br><span style="font-size: 1.2em;">3/10/25/69</span>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><span style="font-size: 1.2em;">Dissentering aortic</span>  |   |
| 20A. AUTOPSY? (Yes or No)<br><span style="font-size: 1.2em;">YES</span>  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)<br><input type="checkbox"/>  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   |
| 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)  |  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX.)  |   |
| 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">10/25/1969</span> to <span style="font-size: 1.2em;">10/25/1969</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">10/25/1969</span> and that (in (my) (our) opinion) death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |   |   |
| 23A. SIGNATURE<br><span style="font-size: 1.2em;">J.M. Juanteguy</span>  |  | 23B. DATE SIGNED<br><span style="font-size: 1.2em;">10/25/69</span>   |   |
| 23C. PHYSICIAN'S NAME (Type)<br><span style="font-size: 1.2em;">J.M. Juanteguy</span>  |  | 23D. ADDRESS<br><span style="font-size: 1.2em;">University Hospital</span>  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><span style="font-size: 1.2em;">Burial</span>  |  | 24B. DATE<br><span style="font-size: 1.2em;">10/29/69</span>  |   |
| 24C. NAME OF CEMETERY or CREMATORY<br><span style="font-size: 1.2em;">Ft Lincoln Cemetery</span>   |  | 24D. LOCATION (City, town, or county) (State)<br><span style="font-size: 1.2em;">Colmar Manor Pro Georges Md.</span>  |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><span style="font-size: 1.2em;">OCT 29 1969</span>  |  | 25B. NAME OF REGISTRAR<br><span style="font-size: 1.2em;">Robert E. Taylor, M.D.</span>   |   |
| 25C. FUNERAL DIRECTOR<br><span style="font-size: 1.2em;">F. Gasch's Sons</span>  |  | ADDRESS<br><span style="font-size: 1.2em;">Hyattsville, Md.</span>  |   |



# FUNERAL DIRECTOR: IMPORTANT

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|   |                              |   |   |
|---|------------------------------|---|---|
| BALTIMORE CITY HEALTH DEPARTMENT  |                              | REG. NO. <b>69 10606</b>  |   |
| BIRTH NO. <b>0-520</b>  |                              | 69 10606 CERTIFICATE OF DEATH   |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Rufus J. Owens</b>  |                              | 2. DATE AND HOUR OF DEATH<br><b>10-22-69</b> <b>6 15</b> PM.  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                              | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>2201</b>                                    |   |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>South Baltimore General Hospital</b><br><b>43</b>   |                              | C. CITY OR TOWN<br><b>Baltimore</b>   | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|   |                              | E. STREET AND NUMBER<br><b>708 S. Hanover Street</b>  |   |
| 5. SEX<br><b>Male</b>   | 6. RACE<br><b>negro</b>      | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>           | 8. DATE OF BIRTH<br><b>5/10/10</b>  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Janitor</b>   |                              | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>?</b>   | 9. AGE (in years last birthday)<br><b>59</b>  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>  |                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |   |
| 13. FATHER'S NAME<br><b>Paul Owens</b>  |                              | 14. MOTHER'S MAIDEN NAME<br><b>Mary Savage</b>  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>unknown</b>  |                              | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT<br><b>Levia Briscoe</b>   |                              | ADDRESS<br><b>708 S. Hanover St.</b>  |   |
| 18. <b>10-22-69</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>Generalized carcinomatosis</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Branchogenic Carcinoma of R. lung</b> |                              | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <b>Branchogenic Carcinoma of R. lung</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____ |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |
| 19A. DATE OF OPERATION<br><b>21</b>   |                              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-</b>  |   |
| 20A. AUTOPSY? (Yes or No)<br><b>yes</b>   |                              | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>yes</b>  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><b>-</b>   |                              | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>-</b>  |   |
| 21C. WHERE DID INJURY OCCUR?<br><b>-</b>  |                              | (If in Baltimore City, give exact location)   |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br><b>-</b>   |                              | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |   |
| 21F. HOW DID INJURY OCCUR?<br><b>-</b>  |                              |   |   |
| 22. I certify that (H) (this hospital) attended the deceased from <b>10-11-69</b> to <b>10-22-69</b> that (H) (we) last saw the deceased alive on <b>10-22-69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                              |   |   |
| 23A. SIGNATURE<br><b>Eleanor L. Noon M.D.</b>   |                              | 23B. DATE SIGNED<br><b>10-22-69</b>   |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Eleanor L. Noon M.D.</b>   |                              | 23D. ADDRESS<br><b>10 Baltimore General Hospital</b>  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 24B. DATE<br><b>10/27/69</b> | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Mt Auburn Cx</b>   | 24D. LOCATION (City, town, or county) (State)<br><b>Balt City</b>                             |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 29 1969</b>   |                              | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor</b>   |   |
| 25C. FUNERAL DIRECTOR<br><b>108 W. Montgomery</b>   |                              | ADDRESS<br><b>108 W. Montgomery</b>   |   |



B-535 69 10607

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 10607

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Bernetta Bunton

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

1:05 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

1:05 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

6. SEX

Female

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

3/11/1900

10. AGE (In years  
lost birthday)

68

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

477 Oxford Court

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

15. MOTHER'S MAIDEN NAME

Mary Gales

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

14B. KIND OF BUSINESS OR INDUSTRY

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

2 14-018156

18. INFORMANT

Family

ADDRESS

19. 412.4

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10-20-69

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

10/21/69

24C. NAME OF CEMETERY or CREMATORY

Mt Calvary Cem

24D. LOCATION (City, town, or county)

A.A. Co, Md

(State)

21213 Md

25A. DATE REC'D BY HEALTH DEPT.

OCT 29 1969

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

Robert E. Williams

ADDRESS

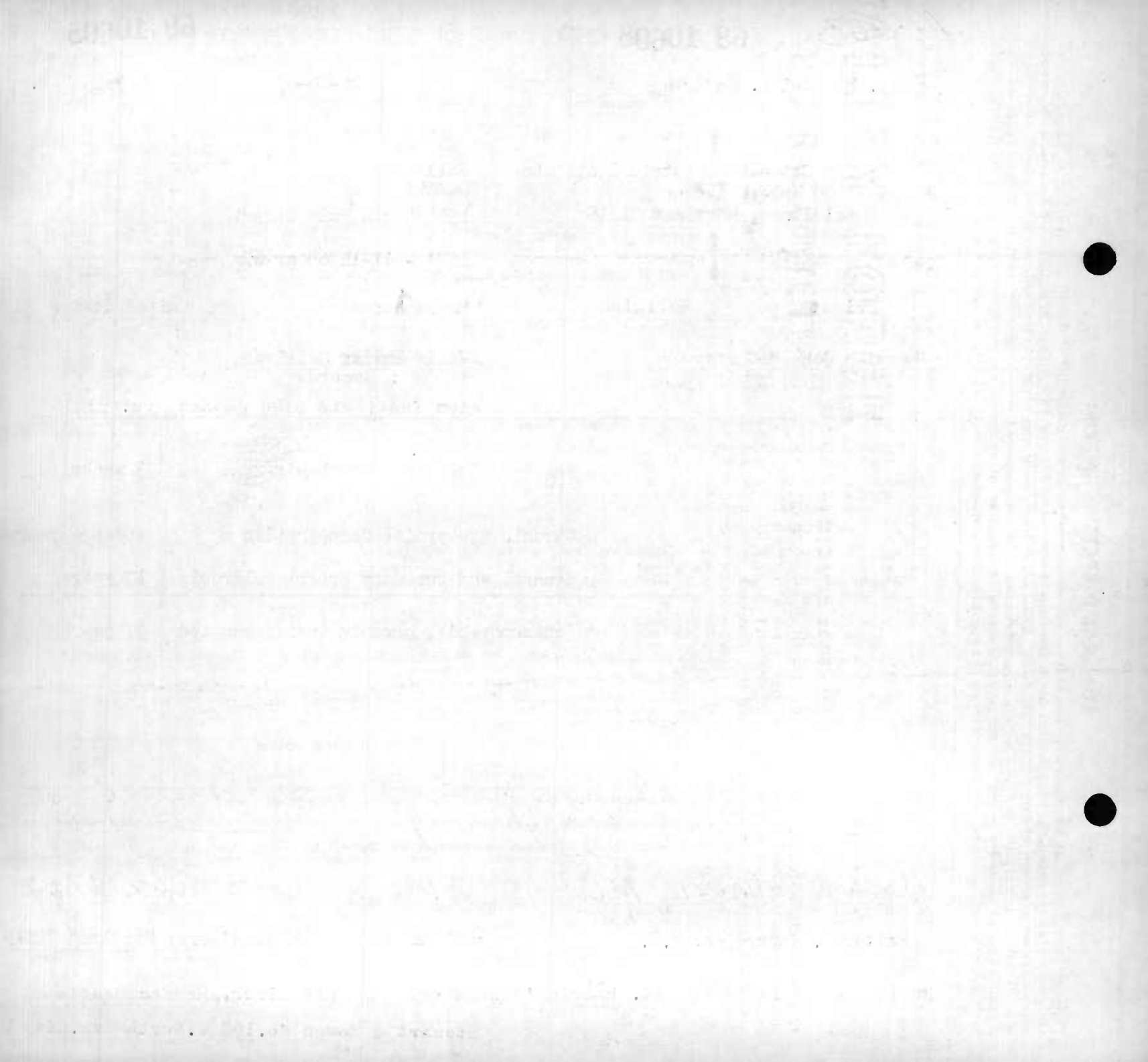
1701 N Bond St





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

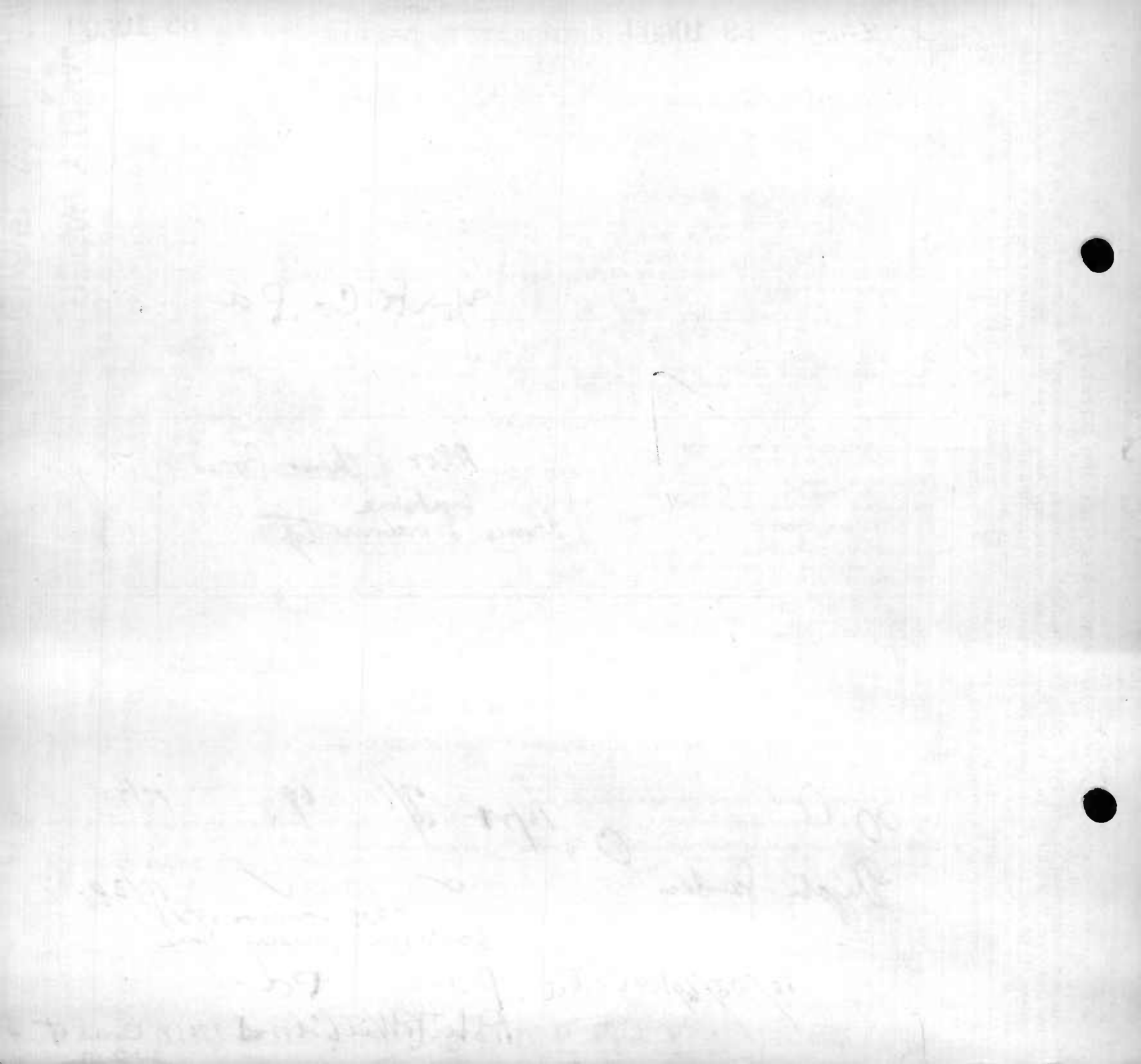
| BALTIMORE CITY HEALTH DEPARTMENT   |                                |   |   | REG. NO. <b>69 10608</b>   |   |
|--|--------------------------------|---|---|--|---|
| <b>M-263</b><br><b>69 10608</b>  |                                | <b>CERTIFICATE OF DEATH</b>   |   |  |   |
| <b>1. NAME OF DECEASED</b><br>(Type or Print) <b>Rev. Michael V. McCarthy</b>  |                                | <b>2. DATE AND HOUR OF DEATH</b><br><b>10-26-69 3:45 P. M.</b>  |   |  |   |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><br><b>19</b>   |                                | <b>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</b><br>A. STATE <b>Massachusetts</b><br>B. COUNTY <b>V-18</b><br><b>5. STREET AND NUMBER</b><br><b>1598 South Main Street</b>  |   |  |   |
| <b>6. FULL NAME OF HOSPITAL OR INSTITUTION</b><br><b>The Seton Psychiatric Institute</b><br><b>6400 Wabash Avenue</b><br><b>Baltimore, Maryland 21215</b>  |                                | <b>7. CITY OR TOWN</b><br><b>Fall River</b><br><b>8. INSIDE CITY LIMITS?</b><br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |  |   |
| <b>5. SEX</b><br><b>Male</b>   | <b>6. RACE</b><br><b>White</b> | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>  | <b>8. DATE OF BIRTH</b><br><b>1901 - 11-14 68</b> | <b>9. AGE (In years lost birthday)</b><br><b>68</b>                        | <b>10. If Under 1 Yr. Months Days</b><br><b>11. If Under 24 Hrs. Hours Min.</b> |
| <b>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b><br><b>Priest</b>  |                                | <b>10B. KIND OF BUSINESS OR INDUSTRY</b><br><b>Religion</b>   |   | <b>11. BIRTHPLACE (State or foreign country)</b><br><b>Massachusetts</b>   |   |
| <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>United States</b>  |                                | <b>13. FATHER'S NAME</b><br><b>Jeremiah John McCarthy</b>   |   |  |   |
| <b>14. MOTHER'S MAIDEN NAME</b><br><b>Julia <del>Siddie</del> Sullivan</b>   |                                | <b>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</b><br><b>16. SOCIAL SECURITY NO.</b>   |   |  |   |
| <b>17. INFORMANT : Records</b><br><b>Seton Institute 6400 Wabash Ave. 21215</b>  |                                | <b>18. CAUSE OF DEATH</b><br><b>I</b><br><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |   |  |   |
| <b>19. DATE OF OPERATION</b><br><b>4/10/91</b>   |                                | <b>20. AUTOPSY? (Yes or No)</b><br><b>no</b>  |   | <b>21. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> |   |
| <b>22. I certify that (I) (this hospital) attended the deceased from</b> <b>May 3, 1933</b> <b>to</b> <b>October 26, 1969</b> <b>and that in (my) (our) opinion death occurred on the date</b> <b>October 26, 1969</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b> |                                | <b>23. SIGNATURE</b><br><b>Walter O. Jahrreiss, M.D.</b>  |   |  |   |
| <b>24. BURIAL CREMATION, REMOVAL (Specify)</b><br><b>Burial</b>  |                                | <b>25. DATE</b><br><b>10/29/69</b>  |   | <b>26. NAME OF CEMETERY or CREMATORY</b><br><b>St. Patrick's Cemetery</b>  |   |
| <b>27. LOCATION (City, town, or county) (State)</b><br><b>Fall River, Massachusetts</b>  |                                | <b>28. DATE REC'D BY HEALTH DEPT.</b><br><b>OCT 29 1969</b>   |   |  |   |
| <b>29. NAME OF REGISTRAR</b><br><b>Robert E. Fisher, M.D.</b>  |                                | <b>30. FUNERAL DIRECTOR</b><br><b>Stewart &amp; Mowen Co. 108 W. North Ave. City 1</b>  |   |  |   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |   |   |
|--|--|---|---|
| BALTIMORE CITY HEALTH DEPARTMENT   |  | REG. NO. <b>69 10609</b>  |   |
| BIRTH NO. <b>0-432 69 10609</b>  |  | CERTIFICATE OF DEATH  |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Anna Rulds</b>   |  | 2. DATE AND HOUR OF DEATH<br><b>10/22/69 3:15 P.M.</b>  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Baltimore, Md.</b> B. COUNTY <b>1513</b> |   |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Harrison Nursing Home</b><br><b>72803 Harrison Blvd</b>  |  | C. CITY OR TOWN<br><b>2</b>   | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX <b>M</b> 6. RACE <b>C</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | E. STREET AND NUMBER<br><b>2505 Bayla Highway</b>   |   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House Wife</b>   |  | 8. DATE OF BIRTH<br><b>8/22/78</b> 9. AGE (In years last birthday) <b>91</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>York Co. Pa</b>                               |
| 13. FATHER'S NAME<br><b>Joseph Dorsey</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |  | 14. MOTHER'S MAIDEN NAME<br><b>Dola Jones</b>   |   |
| 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><b>Harrison Nursing Home</b> ADDRESS <b>2803 Harrison Blvd.</b>  |   |
| 18. <b>41241</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>ACVD &amp; Chronic Bronch</b>  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 yrs</b>  |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Anemia &amp; malnutrition</b>   |  | (B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>1 yr.</b>   |   |
| (C).....   |  |   |   |
| II   |  |   |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |   |   |
| 19A. DATE OF OPERATION<br><b>0</b>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |
| 20A. AUTOPSY? (Yes or No)  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |   |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)   |   |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |   |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                     |   |
| 21F. HOW DID INJURY OCCUR?   |  |   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>7/1 1969</b> to <b>10/22 1969</b> , that (I) (we) last saw the deceased alive on <b>10/21 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |   |   |
| 23A. SIGNATURE<br><b>Eljah Saunders</b>  |  | 23B. DATE SIGNED<br><b>10/24/69</b>   |   |
| 23C. PHYSICIAN'S NAME (Type)   |  | 23D. ADDRESS<br><b>2300 Garrison Blvd - Harrison Nursing Home</b>   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |  | 24B. DATE<br><b>10/25/69</b>  |   |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Westfield, Pa</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>Pa</b>  |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 29 1969</b>  |  | 25B. NAME OF REGISTRAR<br><b>Robert E. J. [unclear]</b>   |   |
| 25C. FUNERAL DIRECTOR<br><b>Robert E. J. [unclear]</b>   |  | ADDRESS<br><b>1701 N Bond St 31213</b>  |   |



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 10610

BIRTH NO.

|   |  |   |  |
|---|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>EUGENE J. JABLKOWSKI</b><br><b>EUGENE ZABLKOWSKI</b>  |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> M.             |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>002120 Cambridge Street</b>  |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>October 28, 1969 10:45 A.M.</b>  |  |
| 6. SEX<br><b>Male</b>   |  | 7. RACE<br><b>White</b>   |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | C. CITY OR TOWN<br><b>Baltimore</b>   |  |
| 9. DATE OF BIRTH<br><b>12/30/09</b>   |  | 10. AGE (In years lost birthday) <b>59 38</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>   |  | 14B. KIND OF BUSINESS OR INDUSTRY<br><b>Newspaper</b>   |  |
| 15. MOTHER'S MAIDEN NAME<br><b>Mary Balcerowicz</b>   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes WW II</b> |  |
| 17. SECURITY NO.<br><b>212-09-1654</b>  |  | 18. INFORMANT<br><b>Mrs. Mary Adamkiewicz</b>   |  |
| 19. CAUSE OF DEATH<br><b>412.4</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Arteriosclerotic Cardiovascular Disease</b><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |  |   |  |
| 20A. DATE OF OPERATION<br><b>21</b>   |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 21. AUTOPSY? (Yes or No)<br><b>yes (Partial)</b>  |  |   |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                    |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?  |  |   |  |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                   |  |
| 22F. HOW DID INJURY OCCUR?  |  |   |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D.<br>EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED <b>10/29/69</b> |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 24B. DATE<br><b>10/31/69</b>  |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Baltimore National</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 29 1969</b>   |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher, M.D.</b>   |  |
| 25C. FUNERAL DIRECTOR<br><b>M.F. SADOWSKI &amp; SONS</b>  |  | ADDRESS<br><b>1808 EASTERN AVE</b>  |  |

CS 10610

CS 10610

WALTER H. ROBINSON

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# FUNERAL DIRECTOR: IMPORTANT

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| BALTIMORE CITY HEALTH DEPARTMENT   |  | REG. NO. <b>69 10611</b>   |  |
| BIRTH NO. <b>69-20049</b>  |  | 69 10611   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>THOMAS BLAKE REDA</b>  |  | 2. DATE AND HOUR OF DEATH<br><b>Oct. 28 1969 8:10 P. M.</b>  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br><b>Md. Gen Hospital</b>  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>2644</b> |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Md. Gen Hospital</b>   |  | C. CITY OR TOWN <b>BALTIMORE</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |
| 5. SEX <b>Male</b>   |  | 6. RACE <b>White</b>   |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH <b>10/27/69</b>   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Infant</b>   |  | 9. AGE (in years last birthday) <b>29</b>  |  |
| 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>  |  |
| 13. FATHER'S NAME <b>ANTHONY THOMAS REDA</b>   |  | 14. MOTHER'S MAIDEN NAME <b>KATHLEEN Lucille BATEY</b>   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO. <b>NONE</b>  |  |
| 17. INFORMANT <b>Mr. Anthony T. Reda, 5018 Denvview Way</b>  |  | ADDRESS  |  |
| 18. <b>770.0 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>Malrotation of gut</b>   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>29 hrs</b>   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Prematurity</b>   |  | DUE TO, OR AS A CONSEQUENCE OF: <b>29 hrs</b>  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>Placenta Previa + Twinning</b>  |  | DUE TO, OR AS A CONSEQUENCE OF: <b>29 hrs</b>  |  |
| 19A. DATE OF OPERATION <b>None</b>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20A. AUTOPSY? (Yes or No)  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |  |
| 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>27 Oct 1969</b> to <b>Oct 28 1969</b><br>that (I) (we) last saw the deceased alive on <b>28 Oct 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |
| 23A. SIGNATURE <b>John F. Cadden Jr. M.D.</b>  |  | 23B. DATE SIGNED <b>28 Oct 69</b>  |  |
| 23C. PHYSICIAN'S NAME (Type) <b>John F. Cadden, Jr.</b>  |  | 23D. ADDRESS <b>Maryland General Hospital</b>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 24B. DATE <b>10/29/69</b>  |  |
| 24C. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary</b>  |  | 24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>   |  |
| 25A. DATE REC'D BY HEALTH DEPT. <b>OCT 29 1969</b>   |  | 25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>   |  |
| 25C. FUNERAL DIRECTOR <b>M.F. SADOWSKI &amp; SONS, 1808 EASTERN AVE</b>  |  | ADDRESS  |  |



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J-520 69 10612 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 69 10612

BIRTH NO.

|   |   |  |   |  |
|---|---|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>MAMIE JOHNS</b>  |   | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> <b>10-23-69</b>               |   | Hour<br>M.   |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Johns Hopkins Hospital (DOA)</b>   |   | 3. DATE PRONOUNCED DEAD<br>Month Day Year<br><b>October 23, 1969 11:36 A.M.</b>  |   | Hour   |
| 5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>704</b>  |   | C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                      |   |  |
| 6. SEX<br><b>Female</b>   | 7. RACE<br><b>Negro</b>                       | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  |
| 9. DATE OF BIRTH<br><b>10-24-1894</b>   | 10. AGE (In years last birthday)<br><b>73</b> | E. STREET AND NUMBER<br><b>1730 Ashland Avenue</b>   |   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>   |   | 14B. KIND OF BUSINESS OR INDUSTRY<br><b>unknown</b>  |   |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |   | 17. SOCIAL SECURITY NO.<br><b>218-10-6529</b>  |   |  |
| 18. INFORMANT<br><b>Addie Scott</b>   |   | ADDRESS<br><b>same</b>   |   |  |
| 19. <b>412.2 I</b><br>CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Hypertensive cardiovascular disease</b><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) _____<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |   |  |   |  |
| 20A. DATE OF OPERATION  |   | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 21. AUTOPSY? (Yes or No)<br><b>No</b>                                    |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |   | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |   | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |   | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 22F. HOW DID INJURY OCCUR?   |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |  |   |  |
| ACTUAL SIGNATURE<br><b>Charles S. Springate, M.D.</b>   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   | DATE SIGNED<br><b>October 23, 1969</b>                                   |
| EXAMINER'S NAME (Type)  |   | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |  |
|   |   | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 24B. DATE<br><b>10-28-69</b>                  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Int Mtaine Cmt</b>  | 24D. LOCATION (City, town, or county)<br><b>Baltimore</b> | (State)  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 29 1969</b>   |   | 25B. NAME OF REGISTRAR<br><b>John E. Fisher, R.D.</b>  |   | 25C. FUNERAL DIRECTOR<br><b>Elroy Nelson on County Hi</b>                |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                      |  |                                 | REG. NO. <b>69 10613</b>   |  |
|---|----------------------|--|---------------------------------|--|--|
| <div style="font-size: 2em; font-weight: bold;">8-300</div> <div style="font-size: 1.5em; font-weight: bold;">69 10613</div>  |                      | CERTIFICATE OF DEATH   |                                 |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>HELEN SCOTT</b>   |                      | 2. DATE AND HOUR OF DEATH<br><b>Oct 26, 1969</b> <span style="float: right;"><b>3:30 p.m.</b></span>   |                                 |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>THE JOHNS HOPKINS HOSPITAL</b><br><b>BALTIMORE, MD 21205</b>  |                      | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>1002</b><br>C. CITY OR TOWN <b>BALTIMORE</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>1227 E. EAGER STREET</b> |                                 |  |  |
| 5. SEX <b>FEMALE</b>  | 6. RACE <b>NEGRO</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <b>5-13-15</b> | 9. AGE (In years last birthday) <b>54</b>                                | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>  |                      | 10B. KIND OF BUSINESS OR INDUSTRY  |                                 | 11. BIRTHPLACE (State or foreign country) <b>Baltimore Md U.S.A.</b>     |  |
| 13. FATHER'S NAME <b>MAKEL OWENS</b>  |                      | 14. MOTHER'S MAIDEN NAME <b>REBECCA WATTS</b>  |                                 | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>  |                      | 16. SOCIAL SECURITY NO.  |                                 | 17. INFORMANT <b>Vernon Scott Lewis</b> ADDRESS                          |  |
| 18. <b>400.21</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Possible brain stem stroke</b>  |                      | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>Malignant hypertension</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>Arteriosclerotic vascular disease</b><br>(C)   |                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                      |  |                                 |  |  |
| 19A. DATE OF OPERATION <b>D</b>   |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                 | 20A. AUTOPSY? (Yes or No) <b>NO</b>                                      |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)   |                      | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                                 | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) <del>(the doctor)</del> attended the deceased from <b>October 25</b> 19 <b>69</b> to <b>October 26</b> 19 <b>69</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>October 26</b> 19 <b>69</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death. |                      |  |                                 |  |  |
| 23A. SIGNATURE <b>N. Franklin Adkinson, Jr., M.D.</b>   |                      |  |                                 | 23B. DATE SIGNED <b>Oct 26, 1969</b>                                     |  |
| 23C. PHYSICIAN'S NAME (Type) <b>N. FRANKLIN ADKINSON, JR., M.D.</b>   |                      |  |                                 | 23D. ADDRESS <b>Johns Hopkins Hopkins, Baltimore, Md.</b>                |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>  |                      | 24B. DATE <b>10-23-69</b>  |                                 | 24C. NAME OF CEMETERY or CREMATORY <b>W. Calvary Cmt</b>                 |  |
| 24D. LOCATION (City, town, or county) <b>A.A. County Md</b>   |                      | 24E. (State)   |                                 |  |  |
| 25A. DATE REC'D BY HEALTH DEPT. <b>OCT 29 1969</b>  |                      | 25B. NAME OF REGISTRAR <b>John E. Taylor</b>   |                                 | 25C. FUNERAL DIRECTOR <b>Elroy Wilson</b> ADDRESS <b>Brantley Ave</b>    |  |

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| M-420   |  | 69 10614  |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | REG. NO. 69 10614  |  |
| BIRTH NO.   |  |   |  | 1. NAME OF DECEASED<br>(Type or Print) <u>Mollock, Louis</u>   |  |  |  |
| 2. DATE AND HOUR OF DEATH<br><u>10-24-69 10:40 AM</u>   |  |   |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |  |  |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>MD</u> B. COUNTY <u>Baltimore City</u>   |  |   |  | 5. SEX <u>M</u> 6. RACE <u>N</u>   |  |  |  |
| C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |
| E. STREET AND NUMBER <u>1239 Bayard St</u>  |  |   |  | 8. DATE OF BIRTH <u>5-11-1902</u> 9. AGE (in years last birthday) <u>67</u>  |  |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>  |  |   |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>  |  |   |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |  |  |
| 13. FATHER'S NAME <u>John Henry Mollock</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME <u>?</u>  |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>  |  |   |  | 16. SOCIAL SECURITY NO. <u>215-03-880</u>  |  |  |  |
| 17. INFORMANT <u>Wife Florence Mollock</u>  |  |   |  | ADDRESS  |  |  |  |
| 18. <u>162.1 I</u> CAUSE OF DEATH   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.          |  |   |  | (A) IMMEDIATE CAUSE <u>Bronchogenic Carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) _____<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____        |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |   |  |  |  |  |  |
| 19A. DATE OF OPERATION <u>0</u>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No) <u>No</u>  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10-4</u> 19 <u>65</u> to <u>10-24</u> 19 <u>65</u> that (I) (we) last saw the deceased alive on <u>19</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |   |  |  |  |  |  |
| 23A. SIGNATURE <u>MD</u>  |  |   |  | 23B. DATE SIGNED <u>10-24-69</u>   |  | 23C. PHYSICIAN'S NAME (Type) <u>MD</u>                               |  |
| 23D. ADDRESS <u>4128 Buckingham Rd Baltimore MD</u>   |  |   |  | 23E. DEGREE  |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 24B. DATE <u>10-29-69</u>   |  | 24C. NAME OF CEMETERY or CREMATORY <u>White Mt</u>   |  | 24D. LOCATION (City, town, or county) (State) <u>MD</u>              |  |
| 25A. DATE REC'D BY HEALTH DEPT. <u>OCT 29 1969</u>  |  | 25B. NAME OF REGISTRAR <u>Robert E. Taylor M.D.</u>   |  | 25C. FUNERAL DIRECTOR <u>Glenn A. Wilson</u>   |  | ADDRESS <u>Waf.</u>  |  |



Copy of the original

**69 10615** BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** REG. NO. **69 10615**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)**Nancy Knight**

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

**33 Johns Hopkins Hospital**2. DATE OF DEATH Known ☒ Estimated ☐ Month Day Year Hour  
**10 26 69 2:03 P. M.**3. DATE PRONOUNCED DEAD Month Day Year Hour  
**10 26 69 2:03 P. M.**5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **Maryland** B. COUNTY **702**

6. SEX

**Female**

7. RACE

**Negro**B. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

**Baltimore**

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

**April 27-1912**

10. AGE (In years last birthday)

**57**

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

**2524 Ashland St.**

11. BIRTHPLACE (State or foreign country)

**North Carolina**

12. CITIZEN OF WHAT COUNTRY?

**U.S.A.**

13. FATHER'S NAME

**Patrick Wilkins**

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**Housewife**

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

**Lula Shipper**

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

**No**

17. SOCIAL SECURITY NO.

18. INFORMANT

**Julius Knight**

ADDRESS

**Samuel**19. **412.4**

CAUSE OF DEATH

**Arteriosclerotic cardiovascular disease**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

**no**

22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: **Natural causes** ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

**Russell S. Fisher, M.D.**

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

**10-27-69**

24A. BURIAL CREMATION, REMOVAL (Specify)

**Burial**

24B. DATE

**10-31-69**

24C. NAME of CEMETERY or CREMATORY

**Calvary**

24D. LOCATION (City, town, or county)

**Calvary**

(State)

**MD**

25A. DATE REC'D BY HEALTH DEPT.

**OCT 29 1969**

25B. NAME OF REGISTRAR

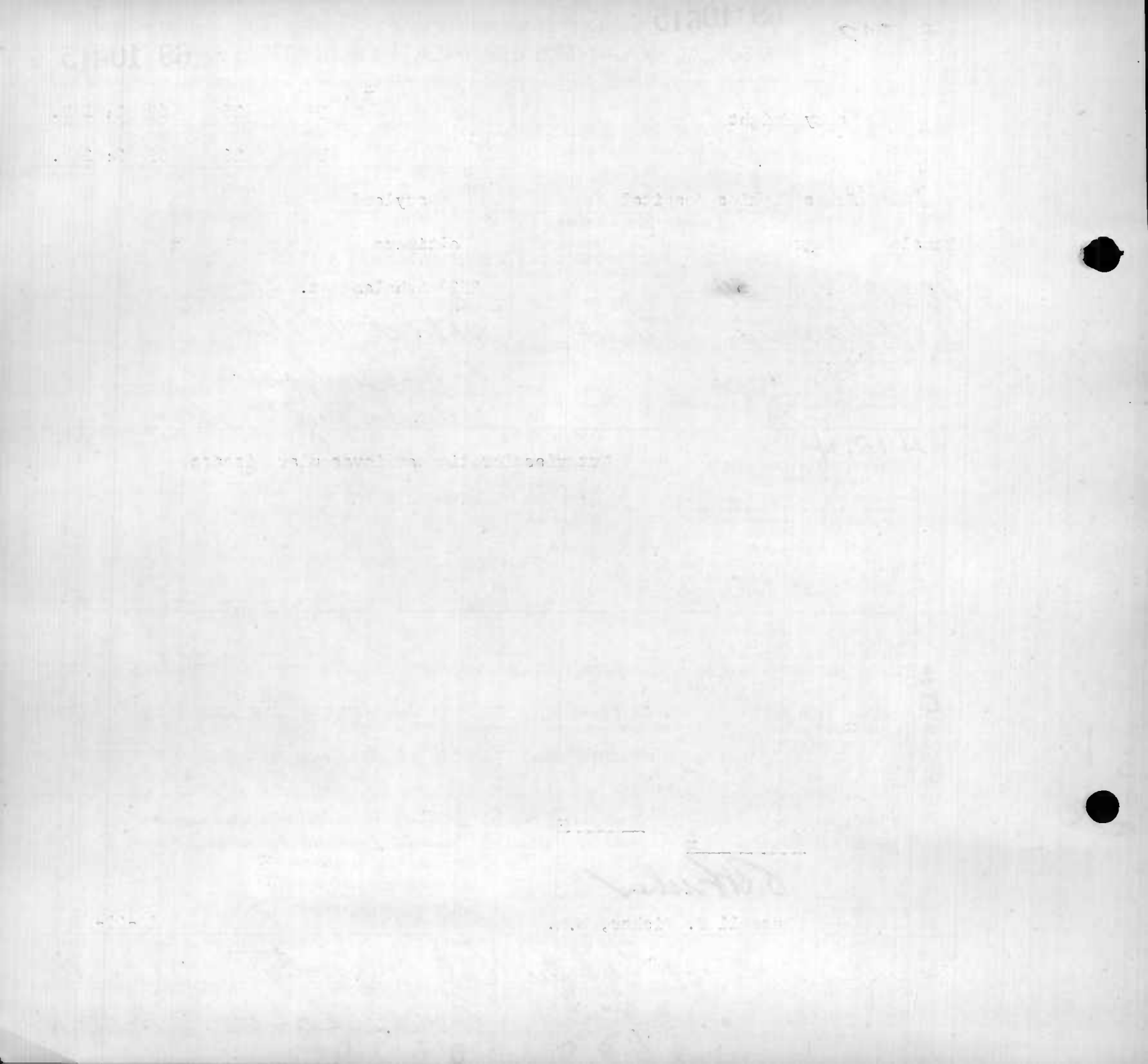
**Russell S. Fisher, M.D.**

25C. FUNERAL DIRECTOR

**Ernest Wilson**

ADDRESS

**1000 Piccadilly Rd**





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |   |  |   |
|---|---|--|---|
| <div style="display: flex; justify-content: space-between;"> <span>W-623</span> <span>69 10616</span> <span>CERTIFICATE OF DEATH</span> </div>  |   | BALTIMORE CITY HEALTH DEPARTMENT<br>REG. NO. 69 10616  |   |
| BIRTH NO. 1. NAME OF DECEASED<br>(Type or Print) <b>CORA L. WRIGHT.</b>   |   | 2. DATE AND HOUR OF DEATH<br><b>10-23-1969. 6:4 P A.M.</b>   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>LUTHERAN HOSPITAL; 730 ASHBURTON ST. BALTIMORE, MD. 21216.</b>  |   | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>U.S.A.</b><br>B. COUNTY <b>MARYLAND. BALTIMORE</b><br>C. CITY OR TOWN <b>BALTIMORE</b><br>D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> <b>1304</b><br>E. STREET AND NUMBER <b>2204 WHITTIER AV. 21217.</b> |   |
| 5. SEX <b>FEMALE</b><br>6. RACE <b>NEGRO</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>NOV 3 - 1894</b><br>9. AGE (In years lost birthday) <b>75.</b>   | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>  |   | 10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>   |   |
| 11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>   |   | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |   |
| 13. FATHER'S NAME <b>Eugene Evans</b>   |   | 14. MOTHER'S MAIDEN NAME <b>Susie Sheppard</b>   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <b>No</b>  |   | 16. SOCIAL SECURITY NO. <b>212-32-2748</b>   |   |
| 17. INFORMANT <b>Charles S Robinson</b>   |   | ADDRESS  |   |
| 18. <b>188X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |   | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>BRONCHO-PNEUMONIA.</b><br>(B) <b>Carcinoma of Bladder with</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <b>Metastasis in Brain.</b>  |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |
| 19A. DATE OF OPERATION <b>2 -</b>   |   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>  |   |
| 20A. AUTOPSY? (Yes or No) <b>yes</b>  |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |   |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  |   |
| 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |   | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10 - 1 - 1969</b> to <b>10 - 23 - 1969</b> , that (I) (we) last saw the deceased alive on <b>10 - 23 - 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.           |   |  |   |
| 23A. SIGNATURE <b>DR. PREM LAL</b>  |   | 23B. DATE SIGNED   |   |
| 23C. PHYSICIAN'S NAME (Type) <b>DR. PREM LAL</b>  |   | 23D. ADDRESS <b>LUTHERAN HOSPITAL 730 ASHBURTON ST. BALTO. MD. 21216</b>   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>  |   | 24B. DATE <b>10-27-69</b>  |   |
| 24C. NAME OF CEMETERY or CREMATORY <b>Int. Ashburton Cent.</b>  |   | 24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>  |   |
| 25A. DATE REC'D BY HEALTH DEPT. <b>OCT 29 1969</b>  |   | 25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>   |   |
| 25C. FUNERAL DIRECTOR <b>Choy G. Nelson</b>   |   | ADDRESS <b>1000 Chantilly Rd</b>   |   |



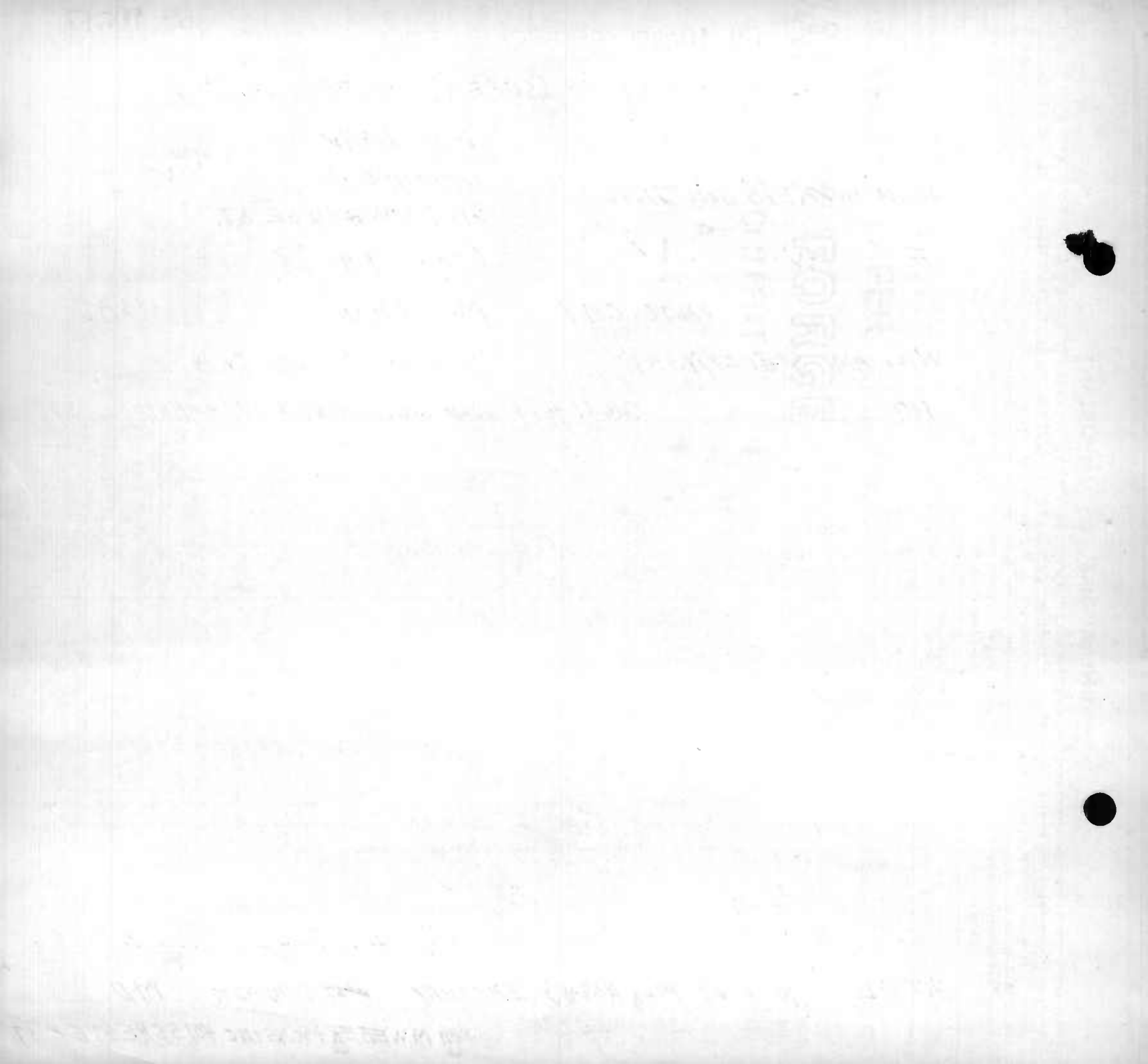
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 69 10617

|  |                       |  |   |
|--|-----------------------|--|---|
| BIRTH NO. 69 10617   |                       | 2. DATE AND HOUR OF DEATH<br>OCTOBER 26, 1969  |   |
| 1. NAME OF DECEASED<br>(Type or Print) JOHN W. SOBCHYNSKI SR. (SUPER)  |                       | M.   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>JOHN HOPKINS HOSPITAL   |                       | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE MARYLAND<br>B. COUNTY BALTIMORE<br>C. CITY OR TOWN<br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER<br>2127 CAMBRIDGE ST. |   |
| 5. SEX<br>F  | 6. RACE<br>W          | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br>6-22-1904                                 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                       | 9. AGE (In years lost birthday)<br>65  | 12. CITIZEN OF WHAT COUNTRY?<br>USA                           |
| 10B. KIND OF BUSINESS OR INDUSTRY<br>BALTO. CITY   |                       | 11. BIRTHPLACE (State or foreign country)<br>MARYLAND  |   |
| 13. FATHER'S NAME<br>WILLIAM SOBCHYNSKI  |                       | 14. MOTHER'S MAIDEN NAME<br>STELLA PODGORSKA   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO   |                       | 16. SOCIAL SECURITY NO.<br>216-01-4673   | 17. INFORMANT<br>JULIA SOBCHYNSKI 2127 CAMBRIDGE ST.          |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |                       | CAUSE OF DEATH<br>(C) approved & med exam. office 1<br>(A) IMMEDIATE CAUSE Cardiovascular disease<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) Hypertension<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>9 yrs.                               |   |
| 19A. DATE OF OPERATION<br>0  |                       | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |
| 20A. AUTOPSY? (Yes or No)  |                       | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                       | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |   |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                       | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)  |   |
| 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                       | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from 1960 to Sept 16 1967, that (I) (we) last saw the deceased alive on Sept 16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |                       |  |   |
| 23A. SIGNATURE<br>George D. Lippert  |                       | 23B. DATE SIGNED<br>10/28/69   |   |
| 23C. PHYSICIAN'S NAME (Type)<br>George D. Lippert  |                       | 23D. ADDRESS<br>426 E. Baltimore St. Baltimore Md 21201  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>BURIAL   | 24B. DATE<br>10-30-69 | 24C. NAME OF CEMETERY or CREMATORY<br>HOLY ROSARY CEMETERY   | 24D. LOCATION (City, town, or county) (State)<br>BALTIMORE MD |
| 25A. DATE REC'D BY HEALTH DEPT.<br>OCT 29 1969   |                       | 25B. NAME OF REGISTRAR<br>J. E. J. J. J.   |   |
|  |                       | 25C. FUNERAL DIRECTOR<br>JOHN M. WEBER & SONS INC 401 SCHESTER ST  |   |



69 10618

BALTIMORE CITY HEALTH DEPARTMENT

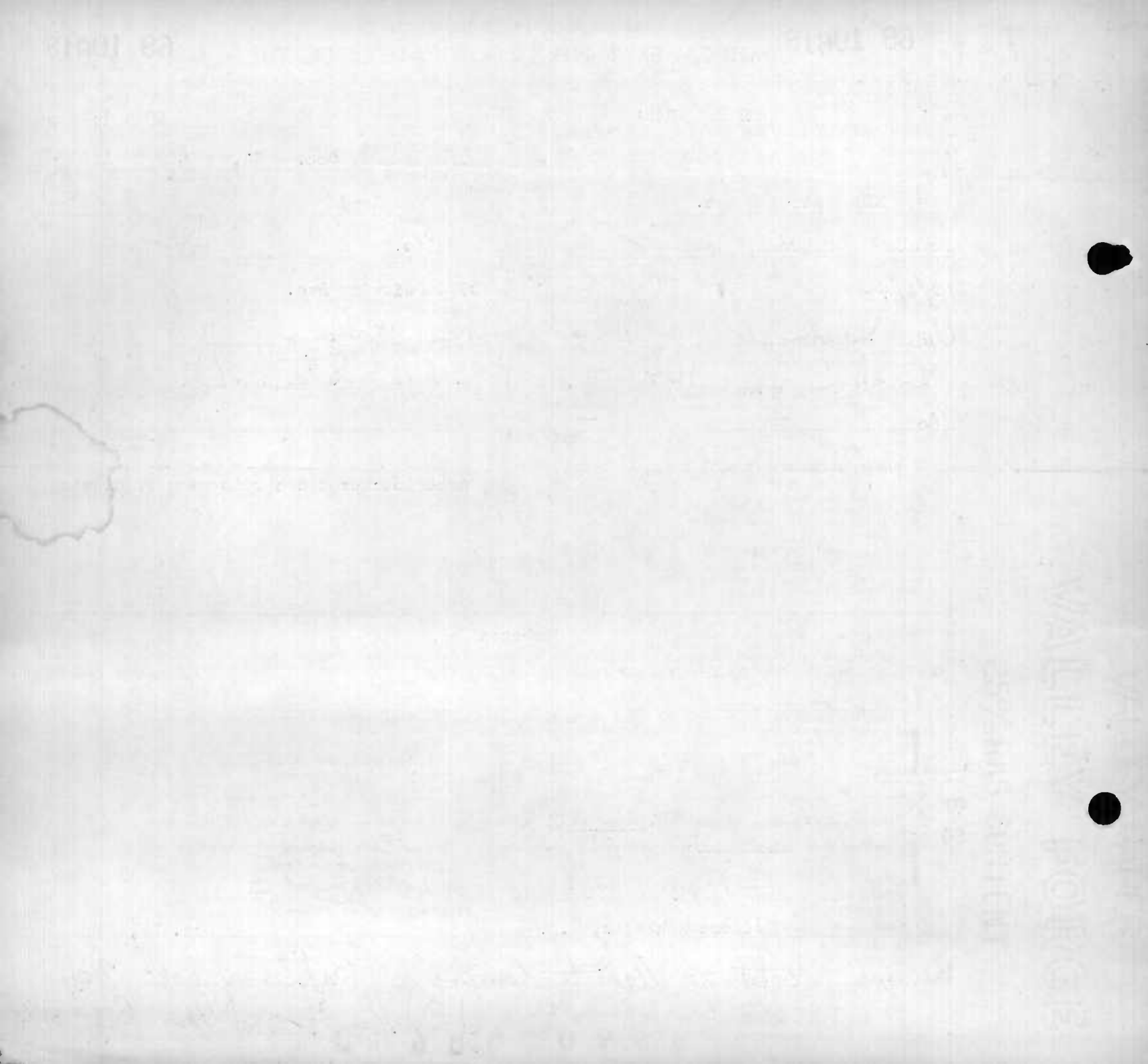
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 10618

BIRTH NO.

REG. NO.

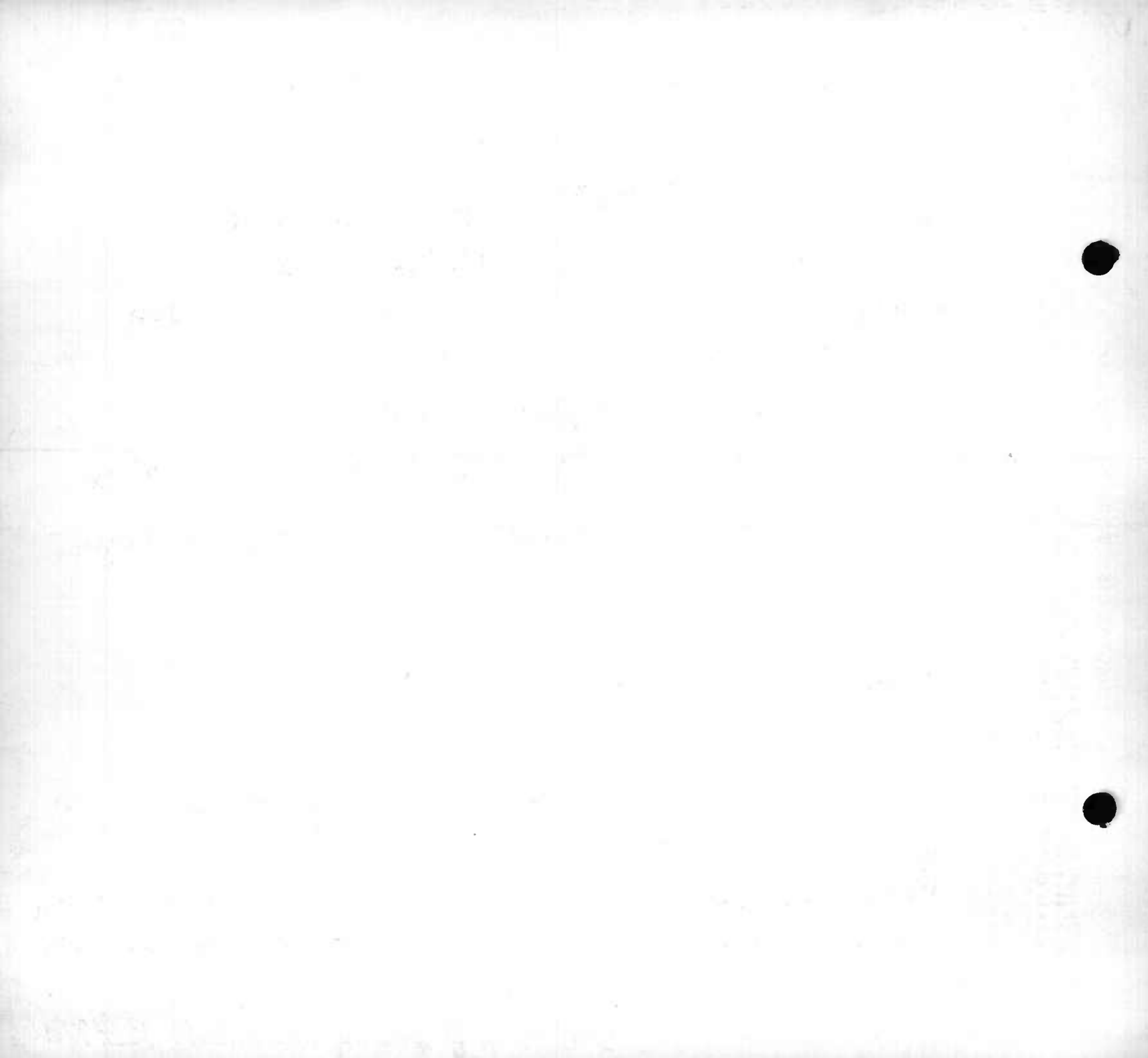
|  |  |  |  |
|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>BERTHA YOUNG</b>  |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> 10 24 69 1:50 p.m.                               |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>00 3704 Fairview Ave.</b>  |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>Oct. 24, 1969 1:50 p.m.</b>   |  |
| 6. SEX<br><b>Female</b>  |  | 7. RACE<br><b>Negro</b>  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | C. CITY OR TOWN<br><b>Balto.</b>   |  |
| 9. DATE OF BIRTH<br><b>12/6/98</b>   |  | 10. AGE (In years lost birthday) <b>71</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Up. Soudan Co.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Teacher</b>  |  | 14B. KIND OF BUSINESS OR INDUSTRY<br><b>Ret.</b>   |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  | 17. SOCIAL SECURITY NO.<br><b>—</b>  |  |
| 18. INFORMANT<br><b>John Calvin</b>  |  | 18. ADDRESS<br><b>3704 Fairview Ave.</b>   |  |
| 19. <b>412.4 + 250.9</b>   |  | CAUSE OF DEATH   |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)   |  | (A) IMMEDIATE CAUSE<br><b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF:   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |  | (B) DUE TO, OR AS A CONSEQUENCE OF:  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  | (C) <b>Diabetes</b>  |  |
| 20A. DATE OF OPERATION   |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  |
| 22D. TIME OF INJURY (APPROX.)  |  | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |
| 22F. HOW DID INJURY OCCUR?   |  | 21. AUTOPSY? (Yes or No)<br><b>No</b>  |  |
| I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br><b>Isidore Mihalakis, M.D.</b>   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>Oct 28</b>   |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Natants Cemetery</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Balt. Md.</b>   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 29 1969</b>  |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher, M.D.</b>  |  |
| 25C. FUNERAL DIRECTOR<br><b>J.B. Johnson</b>   |  | 25D. ADDRESS<br><b>Funeral Home Balt. 17, Md.</b>  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO.   |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | REG. NO.   |  |
|---|--|--|--|--|--|
| 69 10619  |  | 69 10619   |  | 69 10619   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>MRS. ETHEL ADAMS</u>  |  | 2. DATE AND HOUR OF DEATH<br><u>Oct. 21, 1969</u> <u>12 1/2</u> M.   |  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>MD.</u> B. COUNTY <u>402</u>  |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>University of Maryland Hospital</u><br><u>38</u>   |  | C. CITY OR TOWN<br><u>Baltimore</u>  |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 5. SEX <u>F</u>   |  | 6. RACE <u>N</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH<br><u>4/25/26</u>  |  | 9. AGE (in years last birthday)<br><u>43</u>   |  | 10. UNDER 1 Yr. Months Days<br>11. UNDER 24 Hrs. Hours Min.  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Baltimore</u>  |  |
| 13. FATHER'S NAME<br><u>Not available</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>Not available</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO.<br><u>Not available</u>  |  | 17. INFORMANT<br><u>Chart</u>  |  |
| 18. <u>4/10/01</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>II</u><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |  | CAUSE OF DEATH<br><u>Acute Myocardial Infarction</u><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><u>Hypertension - Apparently Essential</u><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>5 Days</u><br><u>12 yrs.</u>  |  |
| 19A. DATE OF OPERATION<br><u>10/19/69</u>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>removal of occlusion - acute</u>  |  | 20A. AUTOPSY? (Yes or No)  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |  | 21E. INJURY OCCURRED<br>White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Oct. 13</u> 19 <u>69</u> to <u>Oct. 21</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>October 21</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |  |  |  |  |  |
| 23A. SIGNATURE<br><u>Mark M. Applefeld, MD</u>  |  | 23B. DATE SIGNED<br><u>October 21, 1969</u>  |  | 23C. PHYSICIAN'S NAME (Type)<br><u>MARK M. APPLEFELD</u>   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |  | 24B. DATE<br><u>10/24/69</u>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><u>Baltimore National</u>  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>OCT 29 1969</u>   |  | 25B. NAME OF REGISTRAR<br><u>Robert E. Taylor, MD</u>  |  | 25C. FUNERAL DIRECTOR<br><u>J. B. Johnson</u>  |  |
| 26A. ADDRESS<br><u>Univ. of Md. Hospital</u>  |  | 26B. ADDRESS<br><u>Baltimore MD</u>  |  | 26C. ADDRESS<br><u>1900 Eutan Pl. Balt. Md.</u>  |  |





69 10620

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 10620

BIRTH NO.

REG. NO.

1. NAME OF DECEASED  
(Type or Print)

MARY STRICKLAND

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

10 25 69

5:05 p. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
HOSPITAL ADDRESS OR LOCATION)  
OR INSTITUTION

Johns Hopkins Hospital D.O.A.

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

Oct. 25, 1969 5:05 p. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

2841

6. SEX

Female

7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

March 23, 1934

10. AGE (In years  
last birthday)

35

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

5104 Belle Ave.

11. BIRTHPLACE (State or foreign country)

York Co., N.C.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Stewart Carter

14. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Nurses Aid

14B. KIND OF BUSINESS OR INDUSTRY

Hospital

15. MOTHER'S MAIDEN NAME

Jannie Powell

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

245 30-052

18. INFORMANT

Nora Crawford

ADDRESS

Balt Md

19. 412.2

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

Hypertensive &amp; arteriosclerotic Cardiovascular disease

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Isidore Mihalakis, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/26/69

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

10/30/69

24C. NAME OF CEMETERY or CREMATORY

Evergreen Cemetery

24D. LOCATION (City, town, or county) (State)

Winston Salem, N.C.

25A. DATE REC'D BY HEALTH DEPT.

OCT 29 1969

25B. NAME OF REGISTRAR

E. J. Fisher, M.D.

25C. FUNERAL DIRECTOR

Ryan Funeral Home Winston Salem, N.C.

ADDRESS

VS177 from Dr.Mihalakis

W-300 1

DR. FISHER  
MED. EXAM

NON MED

FUNERAL DIRECTOR: IMPORTANT

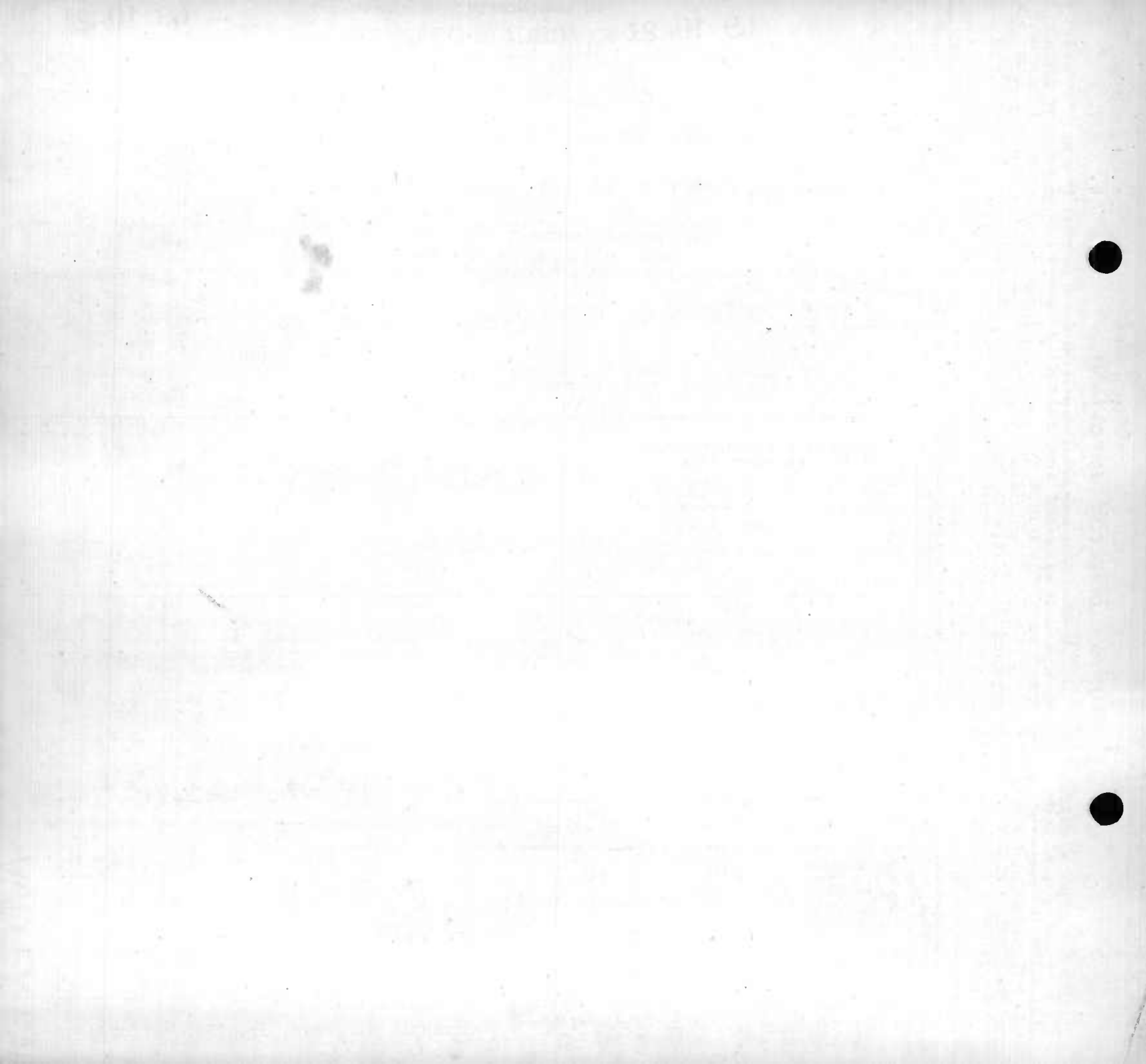
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 10621 BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

69 10621

|  |  |   |   |   |   |
|--|--|---|---|---|---|
| BIRTH NO.  |  | 1. NAME OF DECEASED<br>(Type or Print) <u>White, Marshall M</u>   |   | 2. DATE AND HOUR OF DEATH<br><u>27 Oct 1969</u> <u>9 1/2</u> M.                 |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |   | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>MARYLAND</u><br>B. COUNTY <u>909</u> |   |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>33</u> <u>THE JOHNS HOPKINS HOSPITAL</u><br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |  |   | C. CITY OR TOWN<br><u>BALTIMORE</u>   |   | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |
| 5. SEX<br><u>MALE</u>  |  |   | 6. RACE<br><u>NEGRO</u>   |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH<br><u>9-24-1924</u>   |  | 9. AGE (In years last birthday)<br><u>45</u>  |   | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                       |   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Ret. Gas &amp; Elect Co</u>  |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Gas &amp; Elect Co.</u>   |   | 11. BIRTHPLACE (State or foreign country)<br><u>West Virginia</u>               |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  | 13. FATHER'S NAME<br><u>JAMES White</u>   |   |   |   |
| 14. MOTHER'S MAIDEN NAME<br><u>FLORENCE Mason</u>  |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u> |   |   |   |
| 16. SOCIAL SECURITY NO.<br><u>216-20-8593</u>  |  | 17. INFORMANT ADDRESS<br><u>Mary Collier 3602 Eversley St.</u>  |   |   |   |
| 18. <u>430X1</u> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><u>Pulmonary embolus</u><br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |  |   |   |   |   |
| 19A. DATE OF OPERATION<br><u>2</u>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)<br><u>yes</u>   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                              |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)        |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                |   | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that <del>(it)</del> (this hospital) attended the deceased from <u>17 Aug 1969</u> to <u>23 Aug 1969</u> that <del>(it)</del> (we) last saw the deceased alive on <u>23 Aug 1969</u> and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) (did not) view the body after death.  |  |   |   |   |   |
| 23A. SIGNATURE<br><u>Robert A. Norum M.D.</u>  |  |   |   | 23B. DATE SIGNED<br><u>27 Oct</u>   |   |
| 23C. PHYSICIAN'S NAME (Type)<br><u>ROBERT A. NORUM</u>   |  |   |   | 23D. ADDRESS<br><u>THE JOHNS HOPKINS HOSPITAL</u>                               |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |  | 24B. DATE<br><u>10-23-69</u>  |   | 24C. NAME OF CEMETERY or CREMATORY<br><u>Mt. Calvary Cemetery</u>               |   |
| 24D. LOCATION (City, town, or county)<br><u>A.A. Co., Md.</u>  |  | 24E. (State)  |   |   |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>OCT 29 1969</u>  |  | 25B. NAME OF REGISTRAR<br><u>Robert E. Taylor, R.D.</u>   |   | 25C. FUNERAL DIRECTOR ADDRESS<br><u>Marshall W. Jones, Jr. 1735 Harford Ave</u> |   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|--|--|---|--|--|
| 69 10622   |  | BALTIMORE CITY HEALTH DEPARTMENT   |   | REG. NO. 69 10622  |  |
| BIRTH NO.  |  |  |   |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>GEORGE SIMMS</b>   |  |  | 2. DATE AND HOUR OF DEATH<br><b>10-26-69 6:00 P.M.</b>                                |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>South Baltimore Genl Hosp</b>   |  |  | A. STATE<br><b>MD</b>   |  |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |  |  | B. COUNTY<br><b>Harford</b>   |  |  |
| 5. SEX<br><b>M</b>   |  |  | 6. RACE<br><b>C</b>   |  |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  | 8. DATE OF BIRTH<br><b>8-5-85</b>   |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>  |  |  | 9. AGE (In years last birthday)<br><b>84</b>  |  |  |
| 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Longshoreman</b>   |  |  | 11. BIRTHPLACE (State or foreign country)   |  |  |
| 13. FATHER'S NAME<br><b>William Simms</b>  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>MATTIE ?</b>   |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>  |  |  | 16. SOCIAL SECURITY NO.<br><b>252094358</b>   |  |  |
| 17. INFORMANT<br><b>Myrtle Simms</b>   |  |  | ADDRESS<br><b>937 Cherry Hill Rd</b>  |  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Cerebral Thrombosis</b>   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Arteriosclerosis Heart Disease</b>  |  |  |   |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |  |   |  |  |
| 19A. DATE OF OPERATION   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No)  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>12:00 PM 10-5-69</b> to <b>6:00 PM 10-26-69</b> that (I) (we) last saw the deceased alive on <b>6:00 PM 10-26-69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |   |  |  |
| 23A. SIGNATURE<br><b>Henry Chen</b>  |  |  | 23B. DATE SIGNED<br><b>10-26-69</b>   |  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>HENRY CHEN MD</b>   |  |  | 23D. ADDRESS<br><b>South Balt Genl Hospital</b>                                       |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 24B. DATE<br><b>10-30-69</b>   |   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>MT. AUBURN CEMETERY</b>         |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>BALTIMORE, MARYLAND</b>  |  | 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 29 1969</b>  |   |  |  |
| 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>  |  | 25C. FUNERAL DIRECTOR<br><b>Marshall Jones</b>   |   |  |  |
| ADDRESS<br><b>1735 Harford Ave</b>   |  |  |   |  |  |

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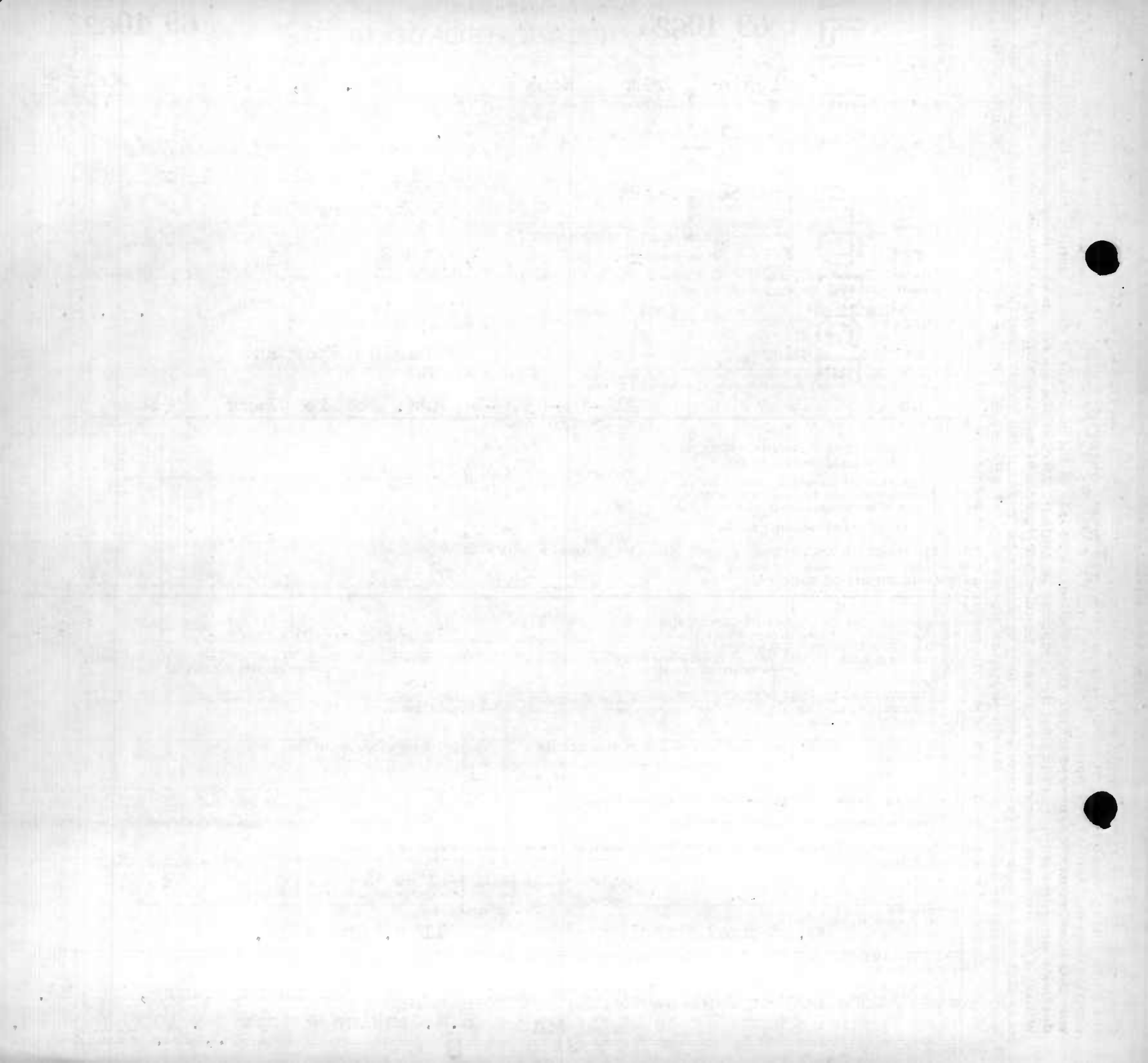
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| 69 10623   |                     |   |  | BALTIMORE CITY HEALTH DEPARTMENT  |  |  |  | REG. NO. 69 10623   |  |   |  |
|--|---------------------|---|--|---|--|--|--|---|--|---|--|
| BIRTH NO.  |                     |   |  |   |  |  |  |   |  |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Virgie Grim Kouk</b>   |                     |   |  |   |  |  |  | 2. DATE AND HOUR OF DEATH<br><b>Oct. 28, 1969</b> <b>12<sup>15</sup> A</b> M.   |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                     |   |  |   |  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b><br>B. COUNTY <b>1201</b> |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>00 235 Chancery Road</b>   |                     |   |  |   |  |  |  | C. CITY OR TOWN<br><b>Baltimore 21218</b>   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| E. STREET AND NUMBER<br><b>235 Chancery Road</b>   |                     |   |  |   |  |  |  |   |  |   |  |
| 5. SEX<br><b>F</b>   | 6. RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>5/5/1888</b>   |  | 9. AGE (In years last birthday)<br><b>81</b>                             |  | If Under 1 Yr. Months Days  |  | If Under 24 Hrs. Hours Min.   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Homemaker</b>  |                     |   |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>             |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |   |  |
| 13. FATHER'S NAME<br><b>Samuel Grim</b>  |                     |   |  |   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Catherine Sherman</b>  |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                     |   |  | 16. SOCIAL SECURITY NO.<br><b>215-05-0370-D</b>   |  | 17. INFORMANT<br><b>Mrs. Dollie Clark</b>                                |  | ADDRESS<br><b>(Same)</b>  |  |   |  |
| 18. <b>412.1</b><br>CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                     |   |  |   |  |  |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>ASCVD</b><br><b>Congestive failure &amp; pulmonary edema</b>             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 yrs</b><br><b>6 weeks</b><br><b>" "</b>  |  |
| (B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>Circulatory failure</b>  |                     |   |  |   |  |  |  | (C) DUE TO, OR AS A CONSEQUENCE OF:<br><b>g.d. Hemorrhage 2x's</b>  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Dec '67 &amp; Jan '68</b>                  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                     |   |  |   |  |  |  |   |  |   |  |
| 19A. DATE OF OPERATION<br><b>0</b>   |                     |   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><b>No</b>                                   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |   |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)  |                     |   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |   |  |   |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  |                     |   |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |   |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>12/27</b> <b>1967</b> to <b>1/28</b> <b>1967</b> , that (I) (we) last saw the deceased alive on <b>1/27</b> <b>1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                  |                     |   |  |   |  |  |  |   |  |   |  |
| 23A. SIGNATURE<br><b>Samuel Morrison</b><br>DEGREE   |                     |   |  |   |  |  |  | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>       |  | 23B. DATE SIGNED<br><b>1/29/69</b>  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Dr. Samuel Morrison</b><br>DEGREE   |                     |   |  |   |  |  |  | 23D. ADDRESS<br><b>11 E. Chase St.</b>  |  |   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                     | 24B. DATE<br><b>10/31/69</b>  |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Lorraine Park</b>  |  |  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore County, Md.</b>   |  |   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 29 1969</b>  |                     |   |  | 25B. NAME OF REGISTRAR<br><b>Phyllis E. Fisher, M.D.</b>  |  |  |  | 25C. FUNERAL DIRECTOR<br><b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto., Md. 21212</b>   |  |   |  |





FUNERAL DIRECTOR: IMPORTANT

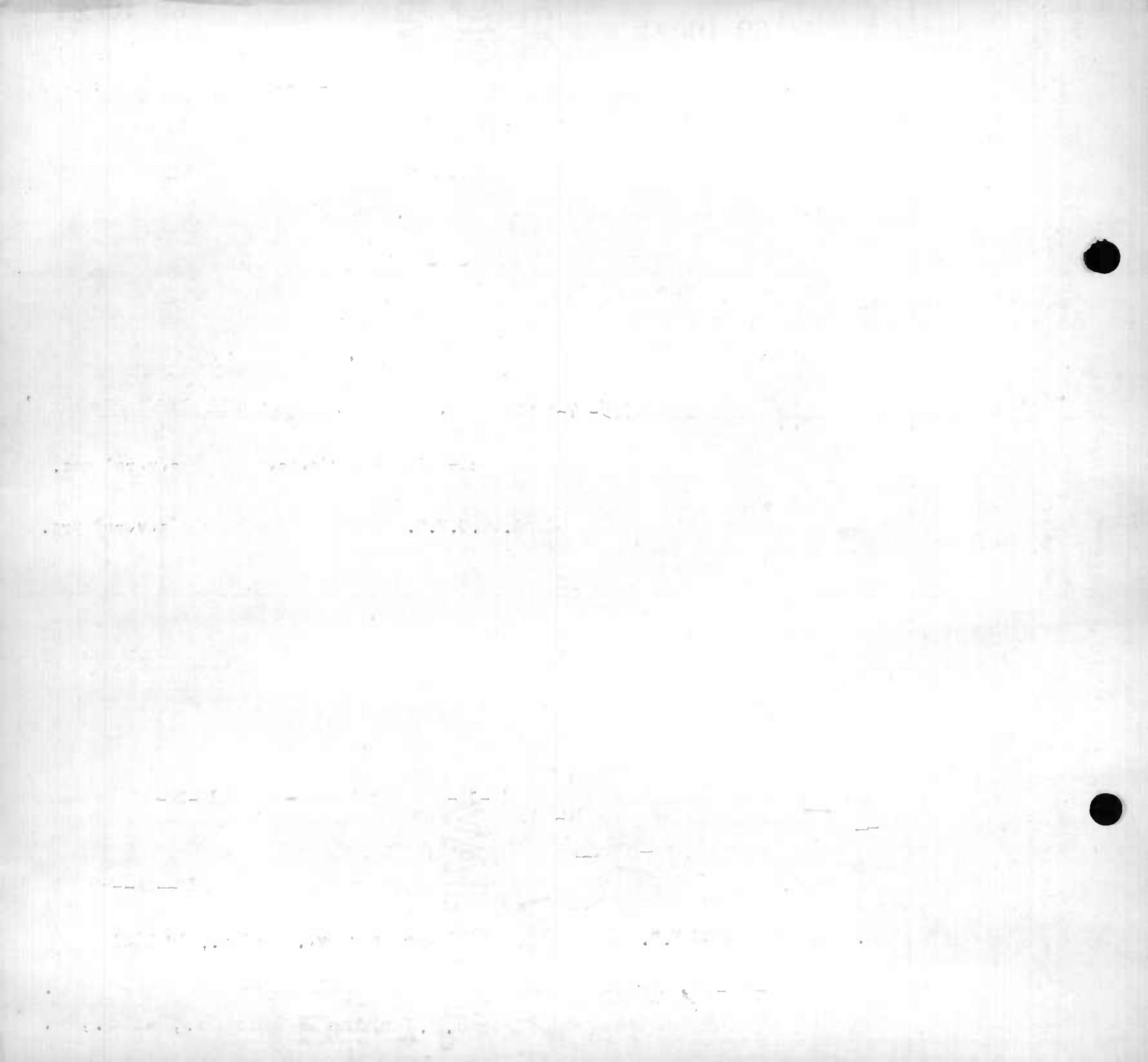
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 10624

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 10624

|  |                  |   |  |   |                                       |
|--|------------------|---|--|---|---------------------------------------|
| BIRTH NO.  |                  | 1. NAME OF DECEASED<br>(Type or Print)  |  | 2. DATE AND HOUR OF DEATH   |                                       |
|  |                  | E. Chat Shanks  |  | 10-28-69 8:05 A.M.  |                                       |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                  |   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)         |                                       |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><br>90 Bolton Hill Nursing & Convalescent Center   |                  |   |  | A. STATE<br>Maryland  |                                       |
|  |                  |   |  | B. COUNTY<br>Baltimore  |                                       |
|  |                  |   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                       |
|  |                  |   |  | E. STREET AND NUMBER<br>1010 St. Paul Street  |                                       |
| 5. SEX<br>Male   | 6. RACE<br>White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>8-16-1893   | 9. AGE (In years last birthday)<br>76 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Representative  |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>Independent Manufacturing  |  | 11. BIRTHPLACE (State or foreign country)<br>Lowell, Michigan                                 |                                       |
| 13. FATHER'S NAME<br>Ernest Shanks   |                  |   |  | 14. MOTHER'S MAIDEN NAME<br>Vesta M.  |                                       |
| 15. Was Deceased Ever in U. S. Armed Forces?<br>(Yes, no or unknown) (If yes, give war or dates of service)<br>Yes WVI   |                  | 16. SOCIAL SECURITY NO.<br>395-07-8952  |  | 17. INFORMANT<br>Mr. John P. O'Ferrall  |                                       |
|  |                  |   |  | ADDRESS<br>1012 Blaustein Bldg.   |                                       |
| 18. CAUSE OF DEATH   |                  |   |  |   |                                       |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                  |   |  |   |                                       |
| (A) IMMEDIATE CAUSE<br>chronic lung disease<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>several mos.   |                  |   |  |   |                                       |
| (B) A. S. C. V. D.<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>several yrs.  |                  |   |  |   |                                       |
| (C) _____  |                  |   |  |   |                                       |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |                  |   |  |   |                                       |
| 19A. DATE OF OPERATION   |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br>No   |                                       |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |                                       |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |                                       |
| 22. I certify that (I) (this hospital) attended the deceased from 10-25-19 69 to 10-28-69 19 69 that (I) (we) last saw the deceased alive on 10-28 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                    |                  |   |  |   |                                       |
| 23A. SIGNATURE<br>E. Ellsworth Cook M.D.   |                  |   |  | 23B. DATE SIGNED<br>10-28-69  |                                       |
| 23C. PHYSICIAN'S NAME (Type)<br>E. ELLSWORTH COOK M.D.   |                  |   |  | 23D. ADDRESS<br>2431 Maryland Ave. Balto., Md. 21218  |                                       |
| 24A. BURIAL CREMATION<br>REMOVAL (Specify)<br>Cremation  |                  | 24B. DATE<br>10-29-69   |  | 24C. NAME OF CEMETERY or CREMATORY<br>Greenmount  |                                       |
| 24D. LOCATION<br>Baltimore   |                  | 24E. (City, town, or county) (State)<br>Md.   |  |   |                                       |
| 25A. DATE REC'D BY HEALTH DEPT.<br>OCT 29 1969   |                  | 25B. NAME OF REGISTRAR<br>Robert E. Jaber, M.D.   |  | 25C. FUNERAL DIRECTOR<br>H. W. Jenkins & Sons Co., Balto., Md.                                |                                       |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| <p><b>B-530 69 10625</b></p> <p style="font-size: 24px; font-weight: bold;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="font-size: 24px; font-weight: bold;">CERTIFICATE OF DEATH</p>  |                                  | <p>REG. NO. <b>355</b></p> <p style="font-size: 24px; font-weight: bold;">69 10625</p>  |  |
| <p><b>BIRTH NO.</b></p> <p>1. NAME OF DECEASED (Type or Print) <b>George E. Bond</b></p>  |                                  | <p>2. DATE AND HOUR OF DEATH <b>October 26, 1969 10:30 A. M.</b></p>  |  |
| <p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Melchor NARSING Home</b></p>  |                                  | <p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <b>Balt</b> B. COUNTY <b>md</b></p> <p>C. CITY OR TOWN <b>846 N Rose St</b> D. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/></p> <p>E. STREET AND NUMBER</p> |  |
| <p>5. SEX <b>Male</b></p>   | <p>6. RACE <b>White</b></p>      | <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>   | <p>8. DATE OF BIRTH <b>8-1-1892</b></p>  |
| <p>9. AGE (In years lost birthday) <b>77</b></p>  |                                  | <p>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</p>  | <p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>2nd motor Bus</b></p> |
| <p>10B. KIND OF BUSINESS OR INDUSTRY <b>Port Helahind</b></p>   |                                  | <p>11. BIRTHPLACE (State or foreign country) <b>W. Va</b></p>   | <p>12. CITIZEN OF WHAT COUNTRY? <b>USA</b></p>   |
| <p>13. FATHER'S NAME <b>John Wesley</b></p>   |                                  | <p>14. MOTHER'S MAIDEN NAME <b>Mrs Kessner</b></p>  |  |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or date of service)</p>  |                                  | <p>16. SOCIAL SECURITY NO.</p>  | <p>17. INFORMANT ADDRESS <b>W. Va</b></p>  |
| <p>18. <b>412.41</b></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> |                                  | <p>CAUSE OF DEATH</p> <p><b>Arteriosclerotic Cardio-vascular Disease</b></p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) DUE TO, OR AS A CONSEQUENCE OF:</p>   |  |
| <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b></p>  |                                  | <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p> <p><b>Laryngectomy</b></p>  |  |
| <p>19A. DATE OF OPERATION <b>0</b></p>  |                                  | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>   |  |
| <p>20A. AUTOPSY? (Yes or No) <b>No</b></p>  |                                  | <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>   |  |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>   |                                  | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>   |  |
| <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>   |                                  | <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>  |  |
| <p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>   |                                  | <p>21F. HOW DID INJURY OCCUR?</p>   |  |
| <p>22. I certify that (I) (this hospital) attended the deceased from <b>June 13, 1969</b> to <b>Oct. 26, 1969</b>, that (I) (we) last saw the deceased alive on <b>October 23, 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.</p>                              |                                  |   |  |
| <p>23A. SIGNATURE <b>Loy M. Zimmerman M.D.</b></p>  |                                  | <p>23B. DATE SIGNED <b>10/26/69</b></p>   |  |
| <p>23C. PHYSICIAN'S NAME (Type) <b>Loy M. Zimmerman M.D.</b></p>  |                                  | <p>23D. ADDRESS <b>3202 Hartford Rd. Baltimore, Md</b></p>  |  |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b></p>   | <p>24B. DATE <b>10/29/69</b></p> | <p>24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b></p>   | <p>24D. LOCATION (City, town, or county) (State) <b>Belair Rd. Baltimore, Md.</b></p>                                  |
| <p>25A. DATE REC'D BY HEALTH DEPT. <b>OCT 29 1969</b></p>   |                                  | <p>25B. NAME OF REGISTRAR <b>266 E. Faber Rd</b></p>  |  |
| <p>25C. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home, 3331 Brehms Lane Baltimore, Md. 21213</b></p>   |                                  | <p>25D. DATE OF DEATH <b>10/26/69</b></p>   |  |

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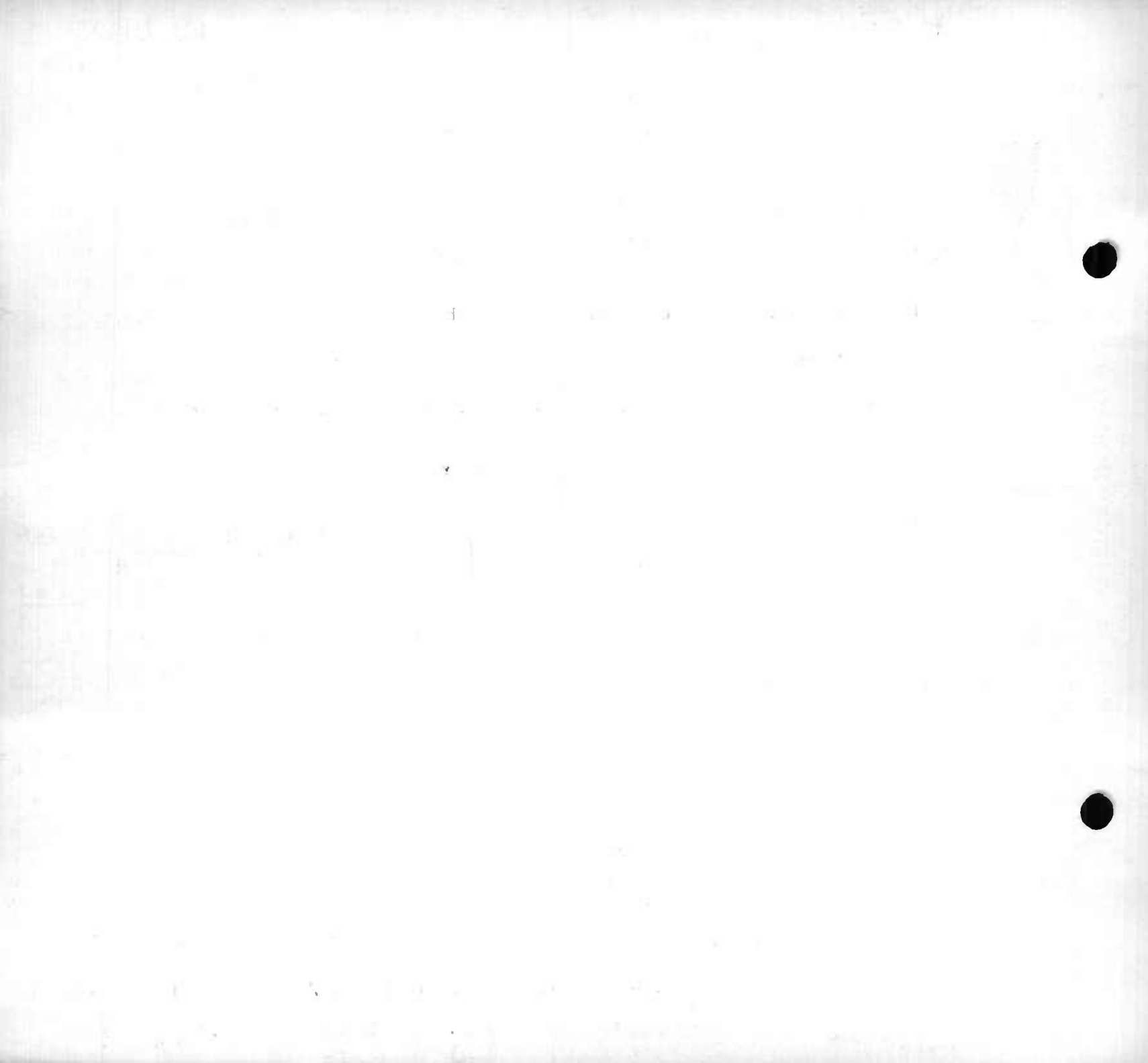
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |                                |   |   | X  |  | REG. NO. 69 10626   |  |
|--|--------------------------------|---|---|--|--|---|--|
| <b>BIRTH NO.</b><br><div style="font-size: 2em; font-weight: bold; float: left; margin-right: 10px;">H-530</div> <div style="font-size: 2em; font-weight: bold; float: right;">69 10626</div>  |                                |   |   | <b>CERTIFICATE OF DEATH</b>  |  |   |  |
| <b>1. NAME OF DECEASED</b><br>(Type or Print) <u>HUNT, William J.</u>  |                                |   |   | <b>2. DATE AND HOUR OF DEATH</b><br><u>October 27, 1969</u> <u>11</u> <u>40</u> <u>P</u> M.  |  |   |  |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><br><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location)<br><u>33 The Johns Hopkins Hospital</u>  |                                |   |   | <b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission)<br><b>A. STATE</b> <u>Ohio</u> <b>B. COUNTY</b> <u>Summit</u> <u>V-32</u> |  |   |  |
|  |                                |   |   | <b>C. CITY OR TOWN</b><br><u>Cuyahoga Falls</u>  |  | <b>D. INSIDE CITY LIMITS?</b><br>YES <input type="checkbox"/> NO <input type="checkbox"/>           |  |
|  |                                |   |   | <b>E. STREET AND NUMBER</b><br><u>2924 Parkwood Drive</u> <u>44224</u>   |  |   |  |
| <b>5. SEX</b><br><u>Male</u>   | <b>6. RACE</b><br><u>White</u> | <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> | <b>8. DATE OF BIRTH</b><br><u>11/29/15</u>                      |  | <b>9. AGE</b> (in years last birthday) <u>53</u>                   | <b>11. Under 1 Yr.</b><br>Months <u>  </u> Days <u>  </u>   | <b>12. Under 24 Hrs.</b><br>Hours <u>  </u> Min. <u>  </u> |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Machine shop owner</u>  |                                |   | <b>10B. KIND OF BUSINESS OR INDUSTRY</b><br><u>Machine Shop</u> |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><u>Ohio</u>    |   | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.A.</u>       |
| <b>13. FATHER'S NAME</b><br><u>John W. Hunt</u>  |                                |   |   | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Louise M. Valentine</u>  |  |   |  |
| <b>15. Was Deceased Ever in U. S. Armed Forces?</b><br>(Yes, no or unknown) (If yes, give war or dates of service)<br><u>no</u>  |                                |   | <b>16. SOCIAL SECURITY NO.</b><br><u>279-09-8373</u>            |  | <b>17. INFORMANT</b><br><u>Mrs. Katherine A. Hunt, Same as # 4</u> |   | <b>ADDRESS</b>   |
| <b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                                |   |   | <b>CAUSE OF DEATH</b><br><b>(A) IMMEDIATE CAUSE</b> <u>RESPIRATORY INSUFFICIENCY</u><br>DUE TO, OR AS A CONSEQUENCE OF:  |  | <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b><br><br><u>2-3 wks</u>                           |  |
|  |                                |   |   | <b>(B) PSEUDOMONAS - KLEBSIELLA PNEUMONIA 1 MONTH</b><br>DUE TO, OR AS A CONSEQUENCE OF:   |  |   |  |
| <b>II</b><br><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b><br><u>MODERATE RENAL FAILURE</u>  |                                |   |   |  |  |   |  |
| <b>19A. DATE OF OPERATION</b><br><u>9-23-69</u>  |                                | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b><br><u>AORTIC STENOSIS</u>   |   | <b>20A. AUTOPSY?</b> (Yes or No)<br><u>YES</u>   |  | <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b><br><u>NO</u>            |  |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>  |                                | <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)   |   | <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)  |  |   |  |
| <b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)   |                                | <b>21E. INJURY OCCURRED</b><br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |   | <b>21F. HOW DID INJURY OCCUR?</b>  |  |   |  |
| <b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>Sept 20</u> <u>19 69</u> <b>to</b> <u>Oct. 27</u> <u>19 69</u><br><b>that (I) (we) last saw the deceased alive on</b> <u>OCT. 27</u> <u>19 69</u> <b>and that (I) (my) (our) opinion death occurred on the date</b><br><b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b> |                                |   |   |  |  |   |  |
| <b>23A. SIGNATURE</b><br><u>Vernon Tolo M.D.</u>   |                                |   |   | <b>23B. DATE SIGNED</b><br><u>October 27, 1969</u>   |  |   |  |
| <b>23C. PHYSICIAN'S NAME (Type)</b><br><u>Vernon T. Tolo, M.D.</u>   |                                |   |   | <b>23D. ADDRESS</b><br><u>The Johns Hopkins Hospital</u>   |  |   |  |
| <b>24A. BURIAL CREMATION, REMOVAL (Specify)</b><br><u>Burial</u>   |                                | <b>24B. DATE</b><br><u>10-30-1969</u>   |   | <b>24C. NAME OF CEMETERY OR CREMATORY</b><br><u>North Lawn Memorial Cemetery</u>   |  | <b>24D. LOCATION</b> (City, town, or county) (State)<br><u>North Hampton Township, Summit, Ohio</u> |  |
| <b>25A. DATE REC'D BY HEALTH DEPT.</b><br><u>OCT 29 1969</u>   |                                | <b>25B. NAME OF REGISTRAR</b><br><u>Robert E. Taylor</u>  |   | <b>25C. FUNERAL DIRECTOR</b><br><u>Wm. Cook-Brooks</u>   |  | <b>ADDRESS</b><br><u>Towson, Md. 21204</u>  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                      |   |                                  |   |  |
|--|----------------------|---|----------------------------------|---|--|
| <div style="display: flex; justify-content: space-between;"> <span><b>D-320</b></span> <span><b>69 10627</b></span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div>   |                      | <b>CERTIFICATE OF DEATH</b>   |                                  | REG. NO. <b>69 10627</b>  |  |
| BIRTH NO. <b>D-320</b>   |                      | 1. NAME OF DECEASED (Type or Print) <b>JAMES CARL DIETZ</b>   |                                  | 2. DATE AND HOUR OF DEATH <b>10/25/69 6:45 P</b>  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                      | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>                |                                  | 5. CITY OR TOWN <b>Dundalk</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>49 North Charles Gen. Hospital</b>   |                      | E. STREET AND NUMBER <b>1787 Brookview Road</b>   |                                  | 21222   |  |
| 5. SEX <b>Male</b>   | 6. RACE <b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>11/30/93</b> | 9. AGE (In years last birthday) <b>75</b>   | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired - Bethlehem Steel Co.</b>  |                      | 10B. KIND OF BUSINESS OR INDUSTRY   |                                  | 11. BIRTHPLACE (State or foreign country) <b>PENNA.</b>   |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>   |                      | 13. FATHER'S NAME <b>JOSEPH DIETZ</b>   |                                  | 14. MOTHER'S MAIDEN NAME <b>EMMA WAMPIER</b>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes WWI</b>   |                      | 16. SOCIAL SECURITY NO. <b>213-07-2469A</b>   |                                  | 17. INFORMANT (Wife) <b>Mrs. Doretta Dietz, Dundalk, Md. 21222</b>  |  |
| 18. <b>533.91</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.)<br><b>MASSIVE GI. HEMORRHAGE</b>   |                      | CAUSE OF DEATH  |                                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                      | (B) <b>PROBABLE PEPTIC ULCER Acute</b><br>DUE TO, OR AS A CONSEQUENCE OF:   |                                  | (C) <b>PULMONARY ATELECTASIS</b>  |  |
| <b>II</b>  |                      |   |                                  |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                      |   |                                  |   |  |
| 19A. DATE OF OPERATION <b>10/20/69</b>   |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CHRONIC + ACUTE CHOLECYSTITIS</b>   |                                  | 20A. AUTOPSY? (Yes or No) <b>YES</b>  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                      | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                                  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10/19 1969</b> to <b>10/25 1969</b> , that (I) (we) last saw the deceased alive on <b>10/25 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                      |   |                                  |   |  |
| 23A. SIGNATURE <b>Matyas Relle M.D.</b>  |                      | 23B. DATE SIGNED <b>10/25/69</b>  |                                  | 23C. PHYSICIAN'S NAME (Type) <b>MATYAS RELLE, M.D.</b>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>   |                      | 24B. DATE <b>10/29/69</b>   |                                  | 24C. NAME of CEMETERY or CREMATORY <b>Balto. National Cemetery</b>  |  |
| 24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>   |                      | 24E. ADDRESS <b>North Charles General Hospital, Balto. Md.</b>  |                                  | 25A. DATE REC'D BY HEALTH DEPT. <b>OCT 29 1969</b>  |  |
| 25B. NAME OF REGISTRAR <b>Robert E. Taylor M.D.</b>  |                      | 25C. FUNERAL DIRECTOR <b>John J. Duda</b>   |                                  | ADDRESS <b>7922 Wise Ave. Dundalk, Md.</b>  |  |

10/10/01

JAMES CARL DIELT

10/22/01

Baltimore  
Maryland

1801 Rockwell Road  
21222

1/16 WHITE

11/30/03

PENNA

112

JOSEPH DIELT

ERMA WINTER

313-0304

MAR 16 01 MEMPHIS

RECEIVED PUBLIC RELS  
BIRMINGHAM ALABAMA

10/20/01  
CROSS + BLUE CIRCLE WITH YES

10/12

10

10/19  
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10/22



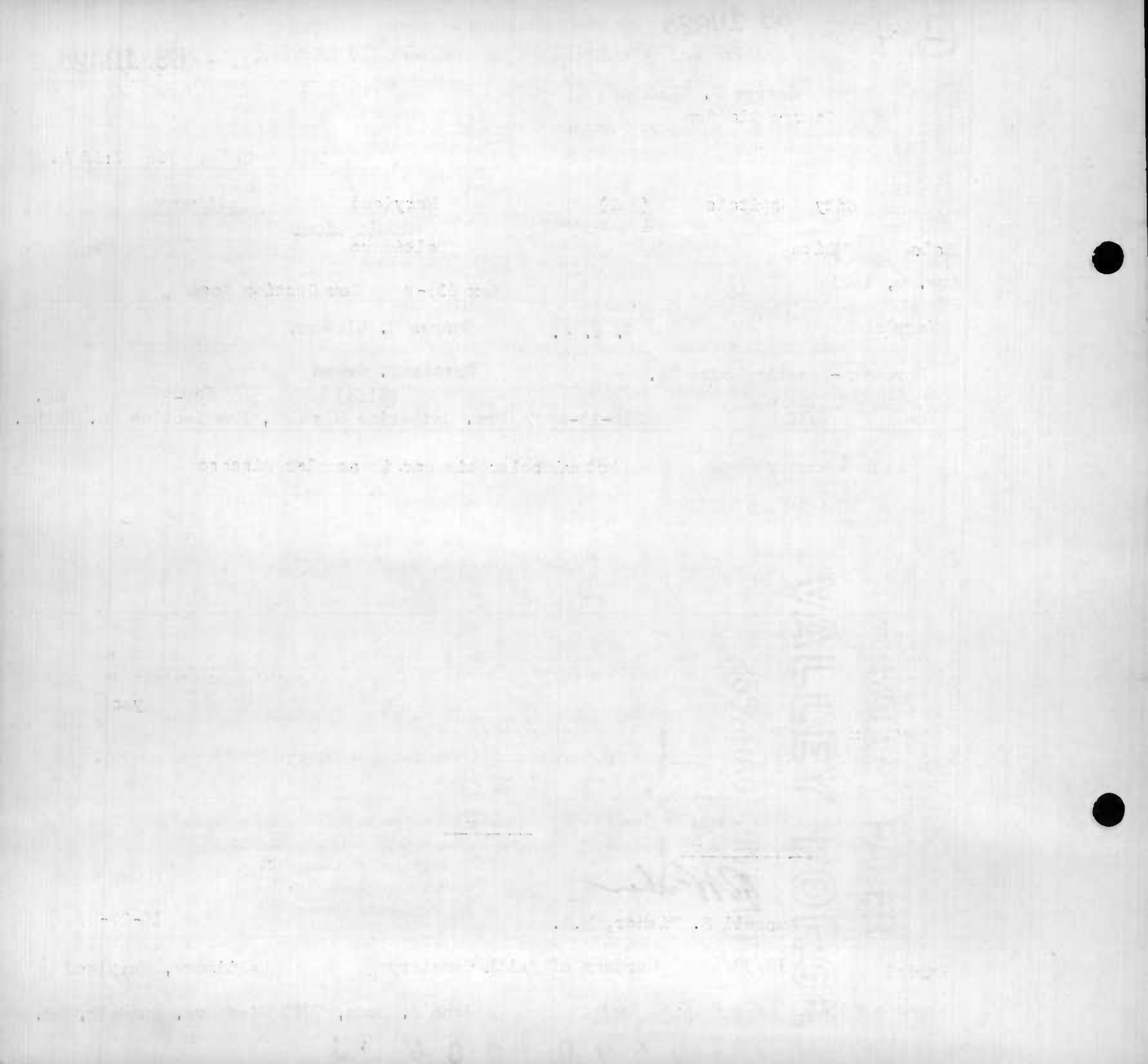
BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 10628

BIRTH NO. G-435 69 10628

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>George V. Gladden</b>  |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Estimated <input type="checkbox"/>   |  | Month Day Year Hour  |  |
| <b>George Gladden</b>  |  |   |  |  |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |  | 3. DATE PRONOUNCED DEAD   |  | Month Day Year Hour  |  |
| <b>City Hospitals (DOA)</b>  |  | <b>10 27 69</b>   |  | <b>7:55 A.M.</b>   |  |
| 6. SEX <b>Male</b>   |  | 7. RACE <b>White</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. DATE OF BIRTH <b>Aug. 6, 1921</b>   |  | 10. AGE (In years last birthday) <b>48</b>  |  | 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>   |  | 13. FATHER'S NAME <b>George V. Gladden</b>  |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman - Westinghouse Co.</b>                             |  |
| 15. MOTHER'S MAIDEN NAME <b>Martha E. Green</b>  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>   |  | 17. SOCIAL SECURITY NO. <b>216-14-4907</b>   |  |
| 18. INFORMANT (Wife) <b>Mrs. Catherine Gladden</b>   |  | 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Arteriosclerotic cardiovascular disease</b><br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF: |  | 20. DATE OF OPERATION  |  |
| 21. AUTOPSY? (Yes or No) <b>yes</b>  |  | 22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 23. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |
| 24. TIME OF INJURY (APPROX.)   |  | 25. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 26. HOW DID INJURY OCCUR?  |  |
| 27. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |  |  |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>   |  | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>  |  | DATE SIGNED <b>10-27-69</b>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 24B. DATE <b>10/30/69</b>   |  | 24C. NAME OF CEMETERY or CREMATORY <b>Gardens of Faith Cemetery</b>  |  |
| 24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>   |  | 25A. DATE REC'D BY HEALTH DEPT. <b>OCT 29 1969</b>  |  | 25B. NAME OF REGISTRAR <b>Russell S. Fisher, M.D.</b>  |  |
| 25C. FUNERAL DIRECTOR <b>John J. Duda</b>  |  | 25D. ADDRESS <b>7922 Wise Ave. Dundalk, Md.</b>   |  |  |  |

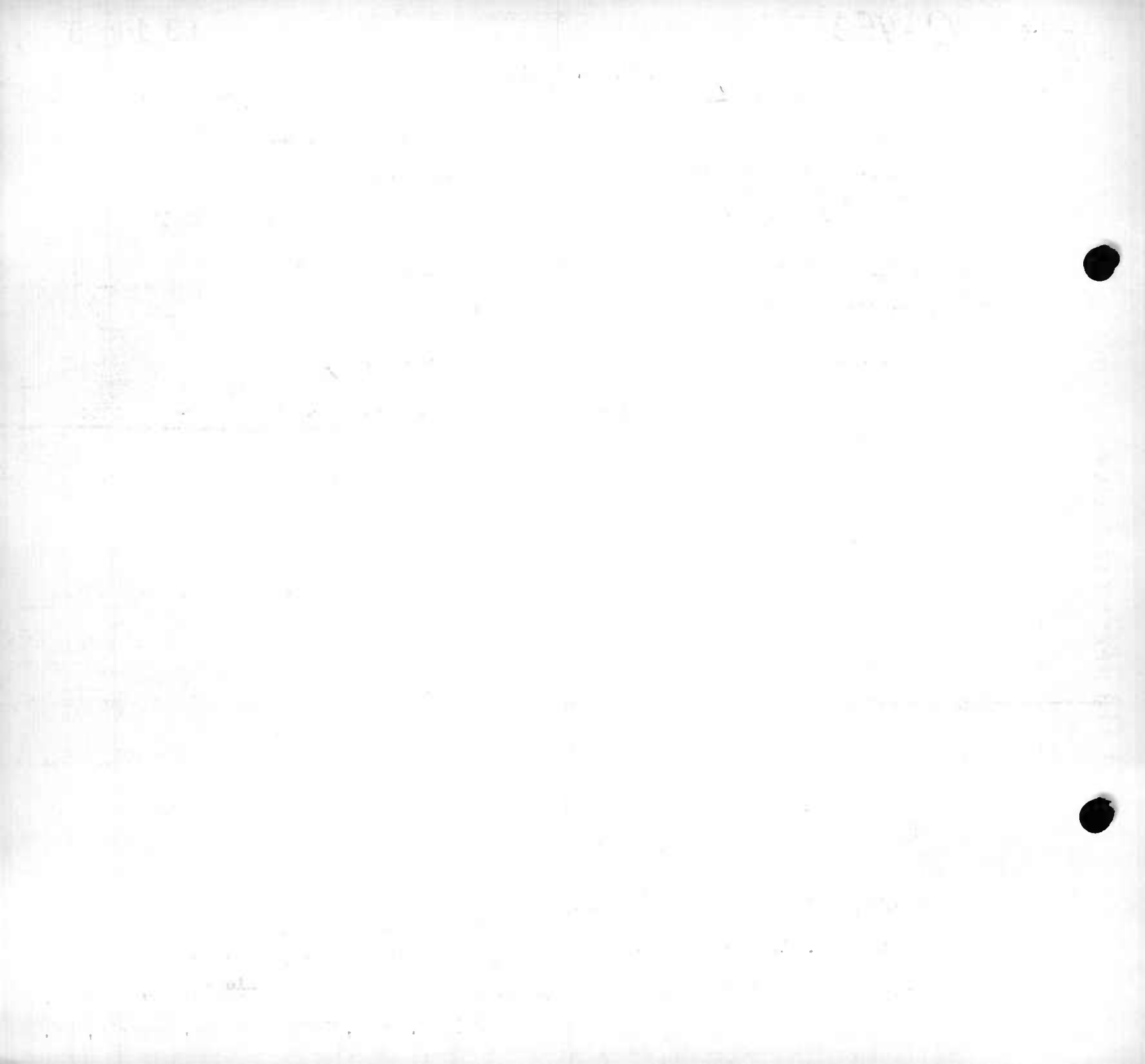
VS 151-REV. 1/1/68



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

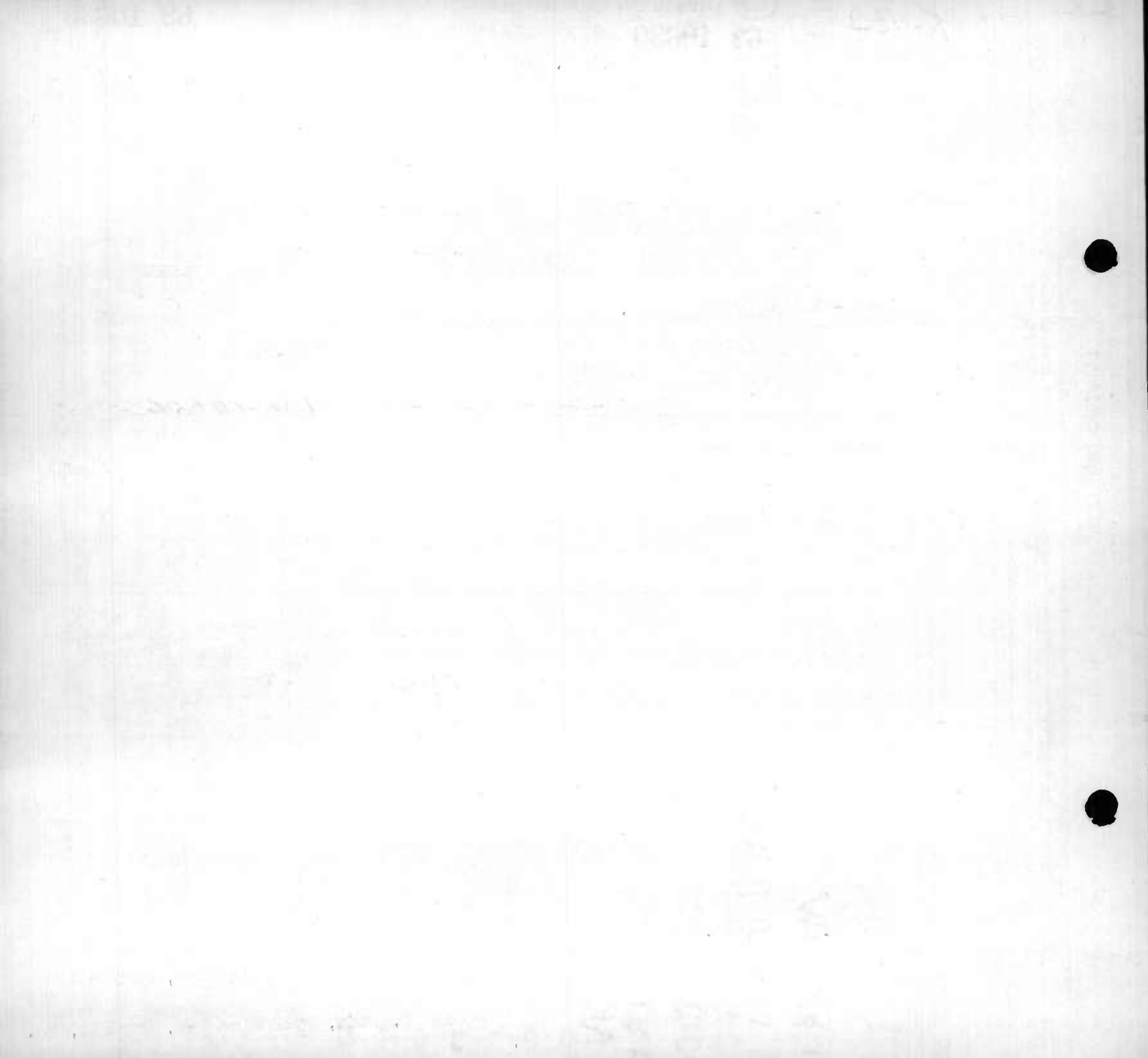
|   |                      |   |  |
|---|----------------------|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT  |                      | REG. NO. <b>69 10629</b>  |  |
| BIRTH NO. <b>C-450</b>  |                      | 69 10629  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>KATHERINE L. CELLINI</b>  |                      | 2. DATE AND HOUR OF DEATH<br><b>OCTOBER 26, 1969 7:00 P.M.</b>  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE CITY HOSPITALS</b><br><b>4940 Eastern Avenue</b><br><b>Baltimore, Maryland 21224</b>  |                      | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>301</b><br>C. CITY OR TOWN <b>Baltimore</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>324 South Dallas Court 21231</b> |  |
| 5. SEX <b>Female</b>  | 6. RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <b>9-23-99</b><br>9. AGE (in years last birthday) <b>70</b><br>10. UNDER 1 Yr. Months <b>11</b> Days <b>11</b> Hours <b>11</b> Min. <b>11</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                      | 10B. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                      | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>John Thomas</b>   |                      | 14. MOTHER'S MAIDEN NAME<br><b>Rose Thompson</b>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                      | 16. SOCIAL SECURITY NO.<br><b>717-07-6416</b>   |  |
| 17. INFORMANT<br><b>BCH Records: 4940 Eastern Ave. 21224</b>  |                      | ADDRESS   |  |
| 18. <b>23-010 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b><br>(A) IMMEDIATE CAUSE <b>SEPSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <b>URINARY TRACT INFECTION</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <b>DIABETES MELLITUS</b> |                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 HR.</b><br><b>UNKNOWN</b><br><b>30 YR.</b>  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>HYPOGLYCEMIC COMA</b>  |                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 DAYS</b>   |  |
| 19A. DATE OF OPERATION <b>0</b>   |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20A. AUTOPSY? (Yes or No)<br><b>No</b>  |                      | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                      | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |  |
| 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                      | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (1) (this hospital) attended the deceased from <b>OCTOBER 23 19 69</b> to <b>OCTOBER 26 19 69</b> that (1) (we) lost saw the deceased alive on <b>OCTOBER 26 19 69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.  |                      |   |  |
| 23A. SIGNATURE<br><b>Michael M. McConnell, M.D.</b>   |                      | 23B. DATE SIGNED<br><b>OCTOBER 26, 1969</b>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Michael M. McConnell, M.D.</b>   |                      | 23D. ADDRESS<br><b>BALTIMORE CITY HOSPITALS</b><br><b>4940 Eastern Ave. 21224</b>   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                      | 24B. DATE<br><b>10/30/69</b>  |  |
| 24C. NAME OF CEMETERY OR CREMATORY<br><b>Crest Lawn Cemetery</b>  |                      | 24D. LOCATION (City, town, or county) (State)<br><b>Marriottsville</b><br><b>Howard Co, Maryland</b>  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 29 1969</b>   |                      | 25B. NAME OF REGISTRAR<br><b>John J. Duda</b>   |  |
| 25C. FUNERAL DIRECTOR<br><b>John J. Duda</b>  |                      | ADDRESS<br><b>7922 Wise Ave. Dundalk, Md.</b>   |  |



## FUNERAL DIRECTOR: IMPORTANT

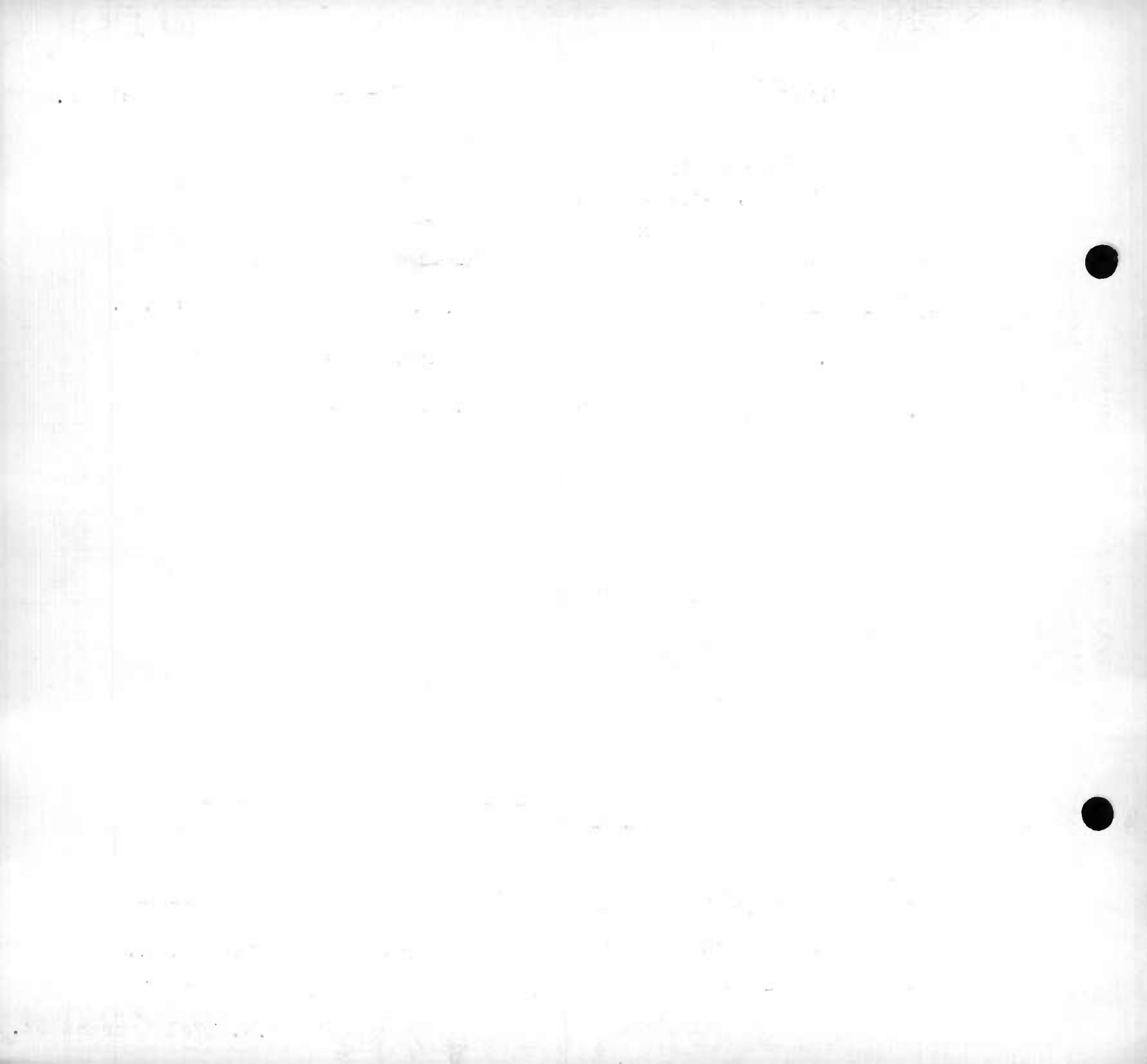
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |   |  |   |  |  |  |   |  |
|---|--|---|--|---|--|--|--|---|--|
| K-432   |  | 69 10630  |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | X  |  | REG. NO. 69 10630   |  |
| BIRTH NO.   |  | 1. NAME OF DECEASED<br>(Type or Print) Frank C. Kolodiej  |  |   |  | 2. DATE AND HOUR OF DEATH<br>10/27/69 2 <sup>10</sup> A M.   |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  |   |  |   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE MARYLAND B. COUNTY BALTIMORE |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>31 BALTIMORE CITY HOSPITALS<br>4940 EASTERN AVENUE<br>BALTIMORE, MARYLAND 21224   |  |   |  |   |  | C. CITY OR TOWN<br>Dundalk   |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| E. STREET AND NUMBER<br>6909 RIDGEWAY RD, 21222   |  |   |  |   |  |  |  |   |  |
| 5. SEX<br>MALE  |  | 6. RACE<br>WHITE  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>11-25-97   |  | 9. AGE (In years last birthday)<br>71   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Retired - Bethlehem Steel Co.  |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br>MARYLAND   |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   |  |
| 13. FATHER'S NAME<br>JAMES Kolodiej   |  |   |  |   |  | 14. MOTHER'S MAIDEN NAME<br>THERESA ?  |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No  |  | 16. SOCIAL SECURITY NO.<br>213-07-6229A   |  | 17. INFORMANT<br>RECORDS-4940 EASTERN AVENUE, BALTIMORE, MD   |  |  |  |   |  |
| 18. 410.9 I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>ACUTE MI   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>36 hr.   |  |   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:  |  |   |  |   |  |  |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br>pneumonia   |  |   |  |   |  | 36 hr.   |  |   |  |
| 19A. DATE OF OPERATION<br>2   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br>yes  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>Yes  |  |   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                   |  | 21C. WHERE DID INJURY OCCUR?<br>J   |  | (If in Baltimore City, give exact location)  |  |   |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |  |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from 10/25 19 69 to 10/27 19 69, that (I) (we) last saw the deceased alive on 10/27 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |   |  |   |  |  |  |   |  |
| 23A. SIGNATURE<br>Lynne I. Neeffe   |  |   |  |   |  | 23B. DATE SIGNED<br>10/27/69   |  |   |  |
| 23C. PHYSICIAN'S NAME (Type)<br>LYNNE I. NEEFE, MD.   |  | 23D. ADDRESS<br>c/o Balto. City Hosps.  |  |   |  |  |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |  | 24B. DATE<br>10/30/69   |  | 24C. NAME OF CEMETERY or CREMATORY<br>Holy Rosary Cemetery  |  | 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Maryland   |  |   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>OCT 29 1969  |  | 25B. NAME OF REGISTRAR<br>Robert E. Faber, M.D.   |  | 25C. FUNERAL DIRECTOR<br>John J. Duda   |  | 25D. ADDRESS<br>7922 Wise Ave. Dundalk, Md.  |  |   |  |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| F-600   |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | 69 10631   |  |
|---|--|--|--|--|--|
| BIRTH NO.   |  | 69 10631   |  | CERTIFICATE OF DEATH   |  |
| 1. NAME OF DECEASED<br>(Type or Print)  |  | Fair, Will Poke  |  | 2. DATE AND HOUR OF DEATH  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  | 10-25-69   |  | 11:55 P. M.  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION  |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                     |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                        |  |
| 39  |  | Provident Hospital<br>1514 Divison Street<br>Baltimore, Maryland 21217                   |  | A. STATE<br>Maryland B. COUNTY<br>Baltimore  |  |
| 5. SEX  |  | 6. RACE  |  | 7. MARRIED   |  |
| Male  |  | Negro  |  | NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 8. DATE OF BIRTH   |  |
| Retired-Beth-Steel  |  |  |  | 4-2-1900   |  |
| 13. FATHER'S NAME   |  | 14. MOTHER'S MAIDEN NAME   |  | 9. AGE (In years last birthday)  |  |
| Unk.  |  | Nannie Fair  |  | 69   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  |
| No.   |  | 213-07-8849  |  | Mrs. Sarah Fair-Wife   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |  | CAUSE OF DEATH   |  | ADDRESS  |  |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)   |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                      |  | Same   |  |
| ANTECEDENT CAUSES   |  | (B) DUE TO, OR AS A CONSEQUENCE OF:  |  | Carcinoma of Prostate 2 years  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |  | (C) DUE TO, OR AS A CONSEQUENCE OF:  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |  | II   |  |  |  |
| 19A. DATE OF OPERATION  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)  |  |
| 0   |  |  |  | No   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                     |  |
| 21D. TIME OF INJURY (APPROX.)   |  | 21E. INJURY OCCURRED   |  | 21F. HOW DID INJURY OCCUR?   |  |
| (Month) (Day) (Year) (Hour)   |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 9-10-69 19 to 10-25-69 19 that (I) (we) last saw the deceased alive on 10-25-69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |  |  |
| 23A. SIGNATURE  |  |  |  | 23B. DATE SIGNED   |  |
| Ralph M. Howard   |  |  |  | 10-27-69   |  |
| 23C. PHYSICIAN'S NAME (Type)  |  |  |  | 23D. ADDRESS   |  |
| Ralph M. Howard   |  |  |  | 1514 Divison Street Baltimore, Md.   |  |
| 24A. BURIAL CREATION, REMOVAL (Specify)   |  | 24B. DATE  |  | 24C. NAME of CEMETERY or CREMATORY   |  |
| Burial  |  | 10-30-69   |  | Carver Memorial Park   |  |
| 25A. DATE REC'D BY HEALTH DEPT.   |  | 25B. NAME OF REGISTRAR   |  | 25C. FUNERAL DIRECTOR  |  |
| OCT 29 1969   |  | Robert E. Taylor, M.D.   |  | MORTON & DYETT F.H. 1701 Laurens St.   |  |
| 25D. LOCATION (City, town, or county) (State)   |  | 25E. FUNERAL DIRECTOR  |  | ADDRESS  |  |
| Laurel, Maryland  |  |  |  |  |  |





1

69 10632 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 68-25024 REG. NO. 69 10632

1. NAME OF DECEASED (Type or Print) **Richard Moore**

2. DATE OF DEATH Known ☐ Month Day Year Hour Estimated ☐ M.

3. DATE PRONOUNCED DEAD Month Day Year Hour **10 27 69 7:37 A.M.**

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) **Provident Hospital (DOA)**

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE **Maryland** B. COUNTY **1402**

6. SEX **Male** 7. RACE **Negro** 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ C. CITY OR TOWN **Baltimore** D. INSIDE CITY LIMITS? YES ☒ NO ☐

9. DATE OF BIRTH **12-28-68** 10. AGE (In years lost birthday) **10** 11. BIRTHPLACE (State or foreign country) **Baltimore, Maryland** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.** 13. FATHER'S NAME **Robert Moore**

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Child** 14B. KIND OF BUSINESS OR INDUSTRY **Child** 15. MOTHER'S MAIDEN NAME **Bernadette Moore**

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **No.** 17. SOCIAL SECURITY NO. **-0-** 18. INFORMANT ADDRESS **M's Bernadette Moore 636 Mosher St.**

19. **795X** CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) IMMEDIATE CAUSE **Sudden death in infancy** DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION **2** 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) **yes**

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 22F. HOW DID INJURY OCCUR?

23. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: **Natural causes** ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Russell S. Fisher, M.D.** CHIEF MEDICAL EXAMINER ☒ DATE SIGNED **10-27-69**

EXAMINER'S NAME (Type) **Russell S. Fisher, M.D.** ASSISTANT MEDICAL EXAMINER ☐ ASSOCIATE MEDICAL EXAMINER ☐

24A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **10-31-69** 24C. NAME of CEMETERY or CREMATORY **Mt. Auburn Cemetery** 24D. LOCATION (City, town, or county) (State) **Baltimore, Maryland**

25A. DATE REC'D BY HEALTH DEPT. **OCT 29 1969** 25B. NAME OF REGISTRAR **Robert E. Fisher, M.D.** 25C. FUNERAL DIRECTOR ADDRESS **MORTON & DYETT F.H. 1701 Laurens St.**

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10835

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

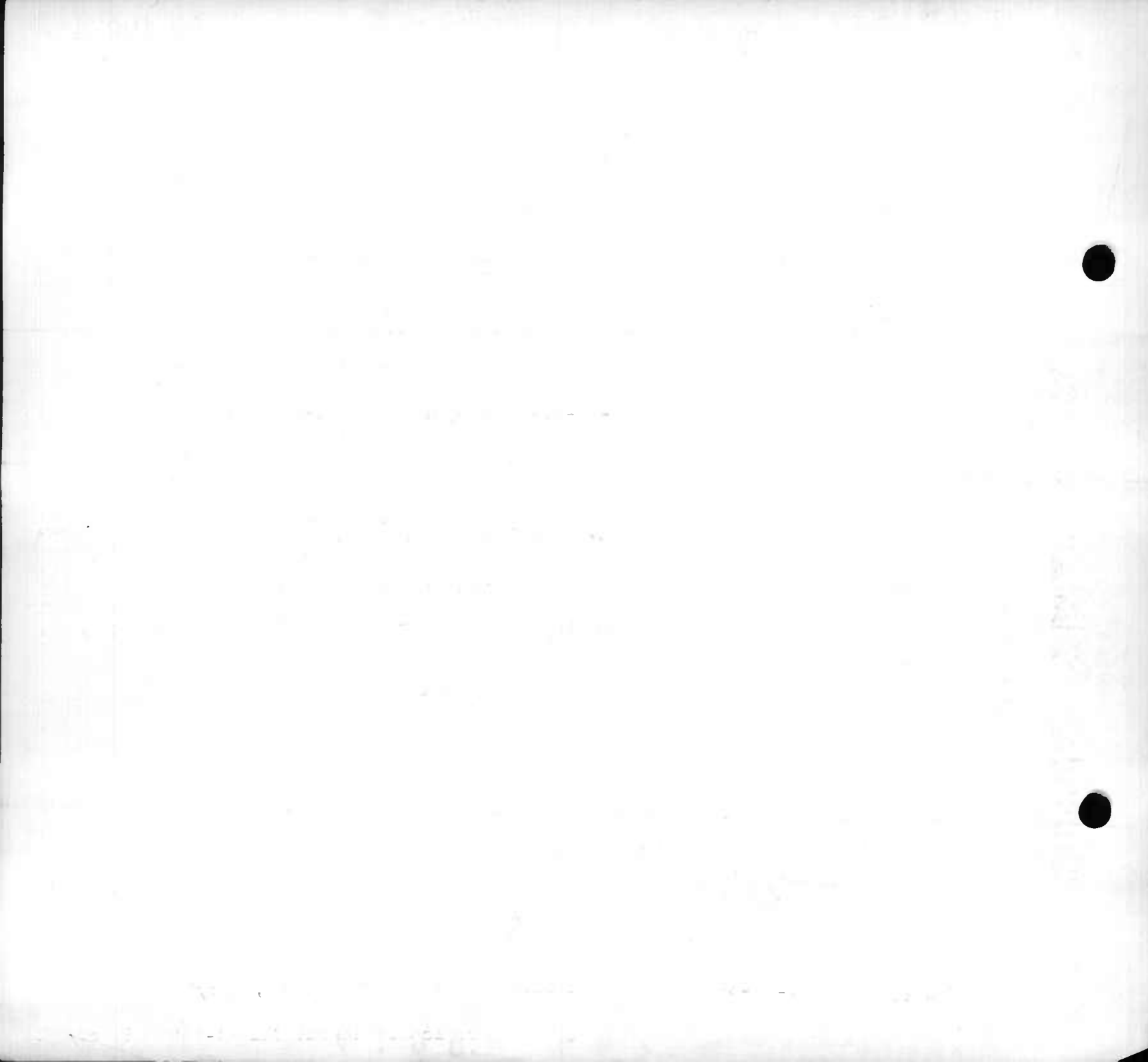
| BALTIMORE CITY HEALTH DEPARTMENT   |  |  |  | REG. NO. <b>69 10633</b>   |  |
|--|--|--|--|--|--|
| 7-435  |  | 69 10633   |  | CERTIFICATE OF DEATH   |  |
| 1. NAME OF DECEASED<br>(Type or Print)   |  | 2. DATE AND HOUR OF DEATH  |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                               |  |
| <b>FLEMING, ROSA (Roser)</b>   |  | <b>10-27-69 11-50 P. M.</b>  |  | <b>Lutheran Hospital for Maryland</b>  |  |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  |  | 5. CITY OR TOWN  |  | 6. INSIDE CITY LIMITS?   |  |
| <b>Maryland</b>  |  | <b>Baltimore</b>   |  | <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>           |  |
| 7. STREET AND NUMBER   |  | 8. DATE OF BIRTH   |  |  |  |
| <b>519 Brice street</b>  |  | <b>03-15-81 88 yrs</b>   |  |  |  |
| 9. SEX   |  | 10. RACE   |  | 11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>          |  |
| <b>F</b>   |  | <b>negro</b>   |  | <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b> |  |
| 12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 13. KIND OF BUSINESS OR INDUSTRY   |  | 14. BIRTHPLACE (State or foreign country)  |  |
| <b>RETIRED</b>   |  | <b>RETIRED</b>   |  | <b>Lynchburg S.C.</b>  |  |
| 15. FATHER'S NAME  |  | 16. MOTHER'S MAIDEN NAME   |  | 17. CITIZEN OF WHAT COUNTRY?   |  |
| <b>Bryan Wright</b>  |  | <b>Emma Wright</b>   |  | <b>U.S.A</b>   |  |
| 18. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |  | 19. SOCIAL SECURITY NO.  |  | 20. INFORMANT  |  |
| <b>NO</b>  |  | <b>NO</b>  |  | <b>Rev. Irving Fleming</b>   |  |
| 21. ADDRESS  |  | 22. CAUSE OF DEATH   |  |  |  |
| <b>519 Brice St.</b>   |  | <b>Cerebro-Vascular accident</b>   |  |  |  |
| 23. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH   |  | 24. ANTECEDENT CAUSES  |  |  |  |
| <b>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</b>  |  | <b>(B) Auricular fibrillation</b>  |  |  |  |
| 25. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |  | 26. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| <b>A</b>   |  | <b>few hours</b>   |  |  |  |
| 27. MEDICAL CERTIFICATION  |  | 28. MEDICAL CERTIFICATION  |  |  |  |
| 29. DATE OF OPERATION  |  | 30. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 31. AUTOPSY? (Yes or No)   |  |
| <b>NO</b>  |  | <b>NO</b>  |  | <b>NO</b>  |  |
| 32. DATE OF INJURY (Month) (Day) (Year) (Hour)   |  | 33. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 34. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |  |
| <b>10-27-69</b>  |  | <b>NO</b>  |  | <b>NO</b>  |  |
| 35. TIME OF INJURY (APPROX.)   |  | 36. INJURY OCCURRED  |  | 37. HOW DID INJURY OCCUR?  |  |
| <b>1</b>   |  | <b>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></b> |  | <b>NO</b>  |  |
| 38. I certify that (I) (this hospital) attended the deceased from <b>10-27-1969</b> to <b>10-27-1969</b> , that (I) (we) last saw the deceased alive on <b>10-27-1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |  |  |
| 39. SIGNATURE  |  | 40. DATE SIGNED  |  | 41. PHYSICIAN'S NAME (Type)  |  |
| <b>Kantilal J Shah M.D.</b>  |  | <b>10-31-69</b>  |  | <b>KANTILAL J SHAH M.D.</b>  |  |
| 42. ADDRESS  |  | 43. NAME OF CEMETERY or CREMATORY  |  |  |  |
| <b>Lutheran Hospital</b>   |  | <b>Arbutus Mem PK.</b>   |  |  |  |
| 44. LOCATION (City, town, or county) (State)   |  | 45. DATE REC'D BY HEALTH DEPT.   |  |  |  |
| <b>Balto. Md.</b>  |  | <b>OCT 29 1969</b>   |  |  |  |
| 46. NAME OF REGISTRAR  |  | 47. FUNERAL DIRECTOR   |  | 48. ADDRESS  |  |
| <b>Morton &amp; Dyett</b>  |  | <b>1701 LAURENS</b>  |  | <b>1701 LAURENS</b>  |  |



# FUNERAL DIRECTOR: IMPORTANT

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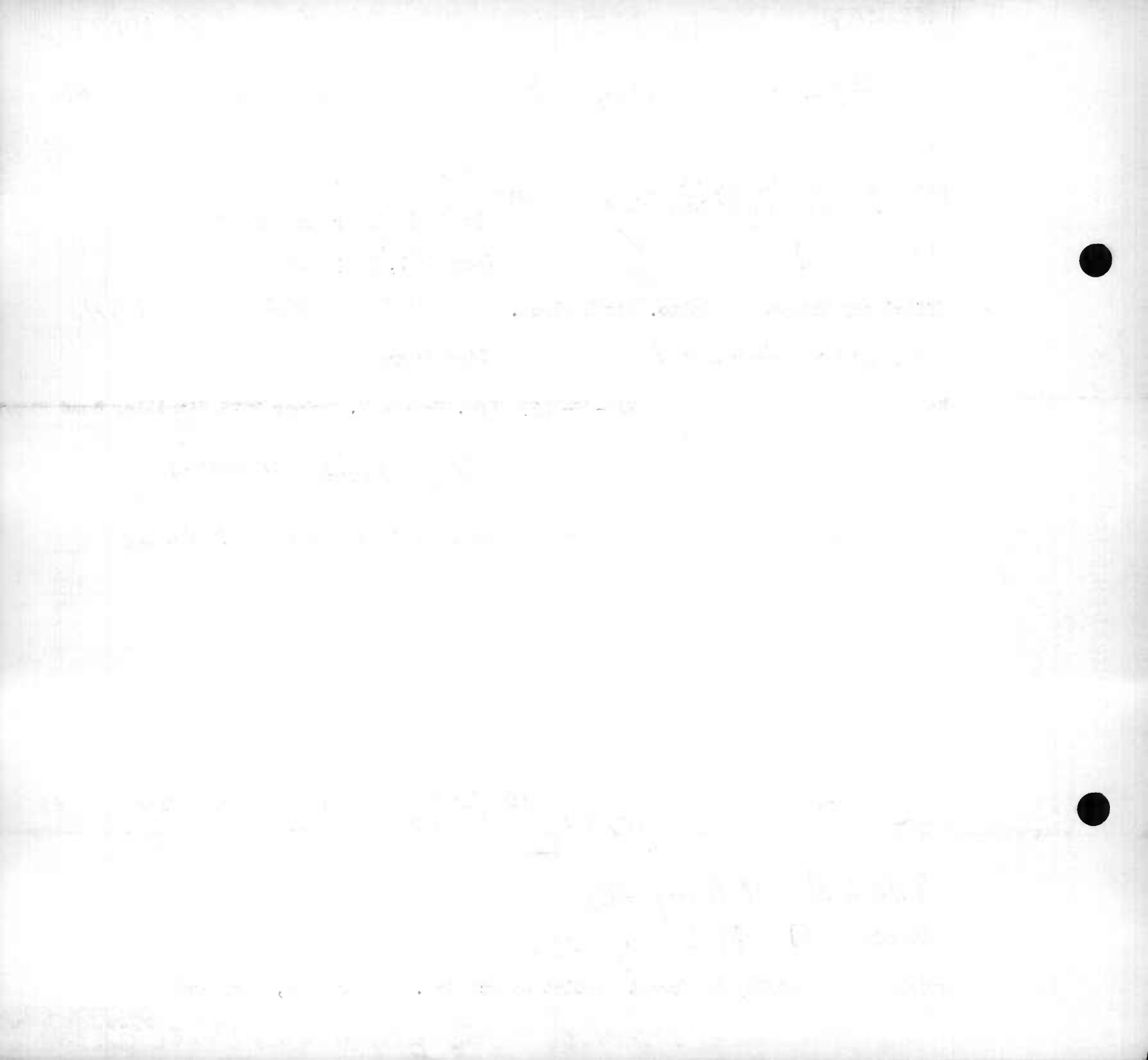
|  |                         |   |                                    |  |  |   |  |
|--|-------------------------|---|------------------------------------|--|--|---|--|
| C-352  |                         | 69 10634  |                                    | BALTIMORE CITY HEALTH DEPARTMENT   |  | REG. NO. 69 10634   |  |
| BIRTH NO.  |                         |   |                                    | CERTIFICATE OF DEATH   |  |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>CATANESE, JOSEPH</b>   |                         |   |                                    | 2. DATE AND HOUR OF DEATH<br><b>10-28-69 06.00</b> M.  |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                         |   |                                    | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>   |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>42 SINAI HOSPITAL OF BALTIMORE</b>  |                         |   |                                    | C. CITY OR TOWN<br><b>BALTIMORE</b>  |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                   |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |                         |   |                                    | E. STREET AND NUMBER<br><b>4104 ROLLINS AVE. #07</b>   |  |   |  |
| 5. SEX<br><b>MALE</b>  | 6. RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5-21-93</b> | 9. AGE (in years last birthday)<br><b>76</b>   | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>CASHIER</b>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY   |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>BALTIMORE</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>JOSEPH CATANESE</b>  |                         |   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>DOMINICA POLITO</b>   |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>  |                         | 16. SOCIAL SECURITY NO.<br><b>218-03-2543</b>   |                                    | 17. INFORMANT ADDRESS<br><b>Josephine DeCola-1554 Stonewood Road # 12</b>  |  |   |  |
| 18. <b>I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>1. 199.1</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>CAUSE OF DEATH: ? Subdural hematoma ? Pulmonary Embolism ? Ventricular Fibrillation</b><br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>? OCCULT myocardial infarction</b><br>(B) <b>A.S.C.V.D. &amp; Coronary insufficiency</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>(C) ? Malignant Neoplasm.</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:<br><b>2 days</b><br><b>3-4 months</b><br><b>many years</b> |                         |   |                                    | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>Arteriosclerotic Cardiovascular disease</b><br>19A. DATE OF OPERATION<br><b>2</b><br>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>yes</b><br>20A. AUTOPSY? (Yes or No)<br><b>yes</b><br>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>(If in Baltimore City, give exact location)</b><br>21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)<br>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>21C. WHERE DID INJURY OCCUR?<br>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)<br>21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/><br>21F. HOW DID INJURY OCCUR? |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10-2</b> 19 <b>69</b> to <b>10-28</b> 19 <b>69</b> that (I) (we) last saw the deceased alive on <b>10-27</b> 19 <b>69</b> and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                         |   |                                    |  |  |   |  |
| 23A. SIGNATURE<br><b>Atalaya</b>   |                         |   |                                    | 23B. DATE SIGNED<br><b>10-28-69</b>  |  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>CARLOS S. VALLEJO, M.D.</b>   |                         |   |                                    | 23D. ADDRESS<br><b>SINAI HOSPITAL OF BALTIMORE</b>   |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 24B. DATE<br><b>10-31-69</b>  |                                    | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cemetery</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 30 1969</b>  |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>   |                                    | 25C. FUNERAL DIRECTOR<br><b>Armocost Funeral Chapel</b>  |  | 25D. ADDRESS<br><b>4600 Liberty Hts</b>   |  |



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| BIRTH NO.  |                     | BALTIMORE CITY HEALTH DEPARTMENT  |  | X REG. NO.  |  | 69 10635   |  |
|--|---------------------|---|--|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>SYDNOR HARRY S</b>   |                     |   |  | 2. DATE AND HOUR OF DEATH<br><b>10/27/69 11 P.M.</b>                                  |  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED/DEAD   |                     |   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>MERCY HOSPITAL INC.<br/>301 ST. PAUL PLACE</b>  |                     |   |  | A. STATE & COUNTY<br><b>Md. Baltimore</b>   |  |  |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |                     |   |  | C. CITY OR TOWN<br><b>BALTIMORE</b>   |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
|  |                     |   |  | E. STREET AND NUMBER<br><b>3625 Eitmiller Road 21207</b>                              |  |  |  |
| 5. SEX<br><b>M.</b>  | 6. RACE<br><b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>January 1, 1903 66</b>   |  | 9. AGE (In years last birthday)<br><b>66</b>                                       |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Efficiency Expert</b>  |                     | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Balto. Gas &amp; Elect.</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>HEATHSVILLE VA.</b>                   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>  |  |
| 13. FATHER'S NAME<br><b>SYDNOR SHELTON</b>   |                     |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Lisa Larry</b>   |  |  |  |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                     | 16. SOCIAL SECURITY NO.<br><b>212-05-4135</b>   |  | 17. INFORMANT ADDRESS<br><b>Mrs. Bertha M. Sydnor 3625 Eitmiller Road 21207</b>       |  |  |  |
| 18. <b>410.9 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>MYOCARDIAL INFARCTION</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> |                     |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |                     |   |  |   |  |  |  |
| 19A. DATE OF OPERATION<br><b>10/26/69</b>  |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?               |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |  |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |  |  |  |
| 22. I certify that <del>(s)</del> (this hospital) attended the deceased from <b>10/26</b> 19 <b>69</b> to <b>10/27</b> 19 <b>69</b> that <del>(s)</del> (we) last saw the deceased alive on <b>10/27</b> 19 <b>69</b> and that <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>(We)</del> (We) (did) ( <del>did not</del> ) view the body after death.                          |                     |   |  |   |  |  |  |
| 23A. SIGNATURE<br><b>Patrick A. Molony MD.</b>   |                     |   |  | 23B. DATE SIGNED  |  | 23C. PHYSICIAN'S NAME (Type)<br><b>PATRICK A. Molony MD.</b>                       |  |
| 23D. ADDRESS   |                     |   |  |   |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                     | 24B. DATE<br><b>10/30/69</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Forest Baptist Church Cem.</b>               |  | 24D. LOCATION (City, town, or county) (State)<br><b>Foreston, Maryland</b>         |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>Oct 30 1969</b>  |                     | 25B. NAME OF REGISTRAR<br><b>Robert E. [illegible]</b>  |  | 25C. FUNERAL DIRECTOR<br><b>Liberty Funeral Director John J. [illegible]</b>          |  |  |  |





# FUNERAL DIRECTOR: IMPORTANT

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|   |                      |   |  |   |                                       |   |  |
|---|----------------------|---|--|---|---------------------------------------|---|--|
| T-650   |                      | 69 10636  |  | BALTIMORE CITY HEALTH DEPARTMENT  |                                       | REG. NO. 69 10636   |  |
| BIRTH NO.   |                      |   |  | M.  |                                       |   |  |
| 1. NAME OF DECEASED<br>(Type or Print)  |                      |   |  | 2. DATE AND HOUR OF DEATH   |                                       |   |  |
| NORA TIERNEY  |                      |   |  | October 26, 1969  |                                       |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                      |   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)   |                                       |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><br>90 CENTURY NURSING HOME   |                      |   |  | A. STATE<br>Maryland  |                                       | B. COUNTY<br>989  |  |
|   |                      |   |  | C. CITY OR TOWN<br>Baltimore  |                                       | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| E. STREET AND NUMBER<br>1102 E. Lanvale St.   |                      |   |  |   |                                       |   |  |
| 5. SEX<br>female  | 6. RACE<br>caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>Feb. 1, 1880  | 9. AGE (In years last birthday)<br>89 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                     |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>housewife  |                      | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br>Ireland  |                                       | 12. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 13. FATHER'S NAME<br>? O'Connell  |                      |   |  | 14. MOTHER'S MAIDEN NAME<br>? ?   |                                       |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces?<br>(Yes, no or unknown) (If yes, give war or dates of service)<br>no   |                      | 16. SOCIAL SECURITY NO.<br>None   |  | 17. INFORMANT<br>Hubert F. Tierney, 1102 E. Lanvale St, Balto.  |                                       |   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)<br><br>412.41<br>CAUSE OF DEATH<br>Cardio Respiratory Failure<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>Arteriosclerotic CVD<br>(B) Semilethargy<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) Terminal Pneumonia<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |                      |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                                       |   |  |
| 19A. DATE OF OPERATION  |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)   |                                       | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR?  |                                       | (If in Baltimore City, give exact location)   |  |
| 21D. TIME OF INJURY (APPROX.)   |                      | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |                                       |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from Feb 25 1964 to Oct 26 1969, that (I) last saw the deceased alive on Oct 26 1969 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                      |   |  |   |                                       |   |  |
| 23A. SIGNATURE<br>Dr. Willard Applefeld   |                      |   |  | 23B. DATE SIGNED  |                                       | 23C. PHYSICIAN'S NAME (Type)  |  |
| 23D. ADDRESS<br>6615 Reisterstown Road, Balto, Md.  |                      |   |  | 23E. ATTENDING PHYSICIAN<br>Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |                                       |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>burial  |                      | 24B. DATE<br>10/29/69   |  | 24C. NAME OF CEMETERY or CREMATORY<br>Parkwood Cemetery   |                                       | 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Md.                               |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>OCT 30 1969  |                      | 25B. NAME OF REGISTRAR<br>Robert E. Taylor  |  | 25C. FUNERAL DIRECTOR<br>Leonard J. Ruck, Inc, Balto, Md. - 14  |                                       | ADDRESS   |  |

Charles H. Brown, Jr.  
(President, 1901-1902)  
George W.  
Thomas (Secretary)

Oct 25

Nov 25

Dec 25

X

Unsubscribed

1

B-220 69 10637 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 69 10637

BIRTH NO.

1. NAME OF DECEASED (Type or Print) J. James Bogucki

2. DATE OF DEATH Known ☐ Month Day Year Hour Estimated ☐ M.

3. DATE OF DEATH Month Day Year Hour 10 27 69 10:10 A.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital (DOA) Maryland

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Maryland 2641

6. SEX Male 7. RACE White 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES ☒ NO ☐

9. DATE OF BIRTH April 12, 1910. 10. AGE (In years lost birthday) 59 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME ? Bogucki

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Warehouseman 15. MOTHER'S MAIDEN NAME Catherine ?

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) Yes W W 2 17. SOCIAL SECURITY NO. 212-10-1272 18. INFORMANT ADDRESS Mrs. Stella Bogucki (Same)

19. CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) no

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 22F. HOW DID INJURY OCCUR?

23. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner 10-27-69

24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 10/31/69. 24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cemetery 24D. LOCATION (City, town, or county) (State) Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT. OCT 30 1969 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. 25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc. Balto. Md. 21214

VS 151-REV. 1/1/68

10637

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99

THE  
OFFICE OF THE  
ATTORNEY GENERAL  
STATE OF NEW YORK  
ALBANY  
JANUARY 10, 1911  
TO THE  
COMMISSIONER OF THE  
DEPARTMENT OF  
CORRECTIONS  
SIR:  
I have the honor to acknowledge the receipt of your letter of the 7th inst. in relation to the matter of the application of the State of New York for the extradition of the person known as JOHN J. CONNELLEY, who is alleged to be a fugitive from justice in the State of New York.

MAILING PROOF

10637

0

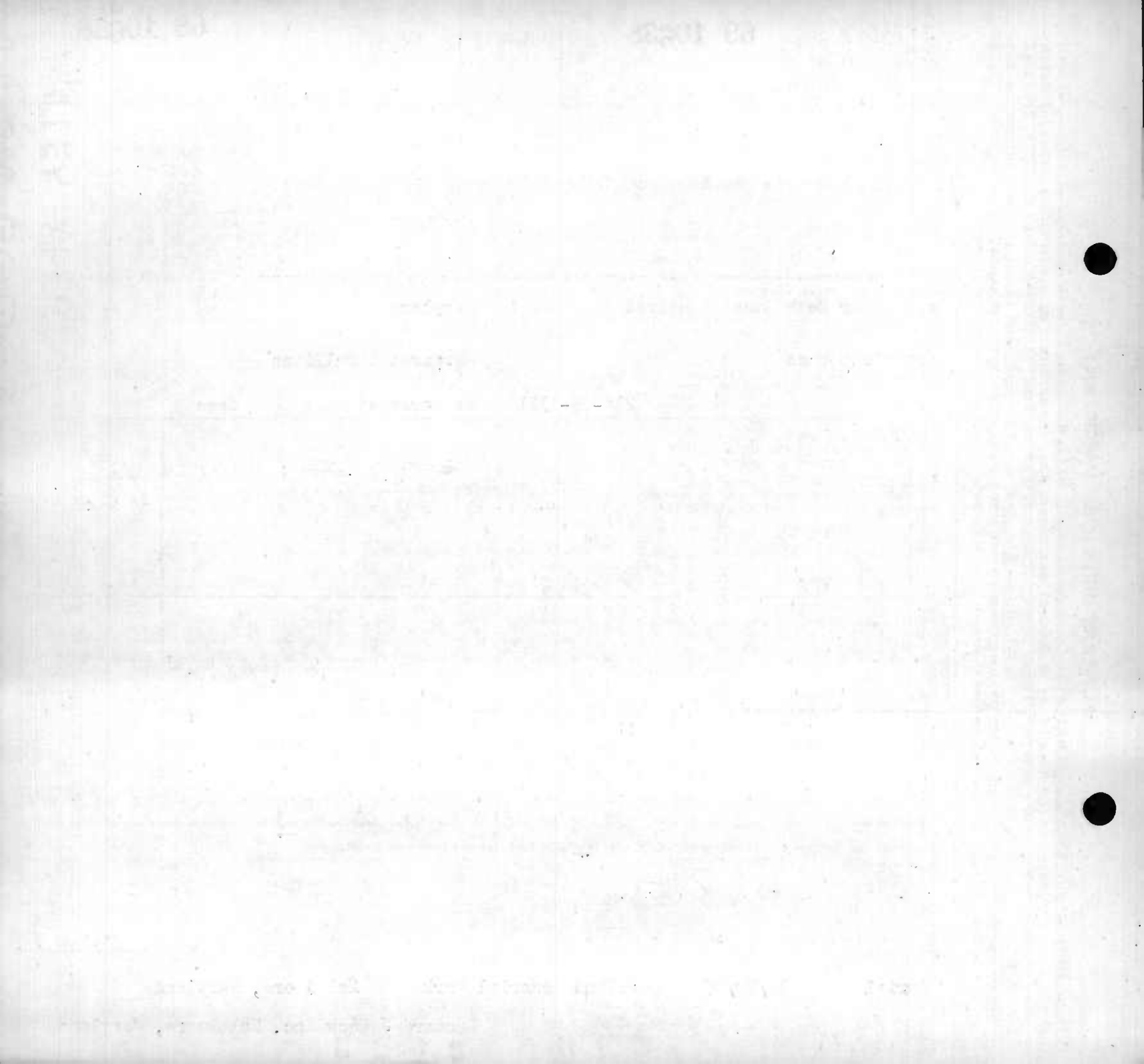
Very respectfully,  
J. J. CONNELLEY

10637

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |          |  |   |  |                   |  |
|--|--|----------|--|---|--|-------------------|--|
| H-200  |  | 69 10638 |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. 69 10638 |  |
| BIRTH NO.  |  |          |  | 1. NAME OF DECEASED<br>(Type or Print) <u>HAAS FRANCIS</u>  |  |                   |  |
| 2. DATE AND HOUR OF DEATH<br><u>Oct. 26, 1969</u> <u>2 PM</u> M.   |  |          |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  |                   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>Montebello State Hospital</u>   |  |          |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |  |                   |  |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>MD</u> B. COUNTY <u>Baltimore City</u>  |  |          |  | C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |                   |  |
| E. STREET AND NUMBER<br><u>3605 Southern Ave.</u>  |  |          |  | 5. SEX <u>M.</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |  |                   |  |
| B. DATE OF BIRTH<br><u>12/14/11</u>  |  |          |  | 9. AGE (In years last birthday) <u>57</u>   |  |                   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Pay Master Beth Steel</u>  |  |          |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Retired</u>   |  |                   |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>   |  |          |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |                   |  |
| 13. FATHER'S NAME<br><u>Francis S Haas</u>   |  |          |  | 14. MOTHER'S MAIDEN NAME<br><u>Margaret L Sullivan</u>  |  |                   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>  |  |          |  | 16. SOCIAL SECURITY NO.<br><u>216-05-1321</u>   |  |                   |  |
| 17. INFORMANT<br><u>Mrs Margaret Hass</u>  |  |          |  | ADDRESS<br><u>Same</u>  |  |                   |  |
| 18. <u>412.1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.              |  |          |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <u>ASHD, CVA, Hypertension</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF: |  |                   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><u>None.</u>   |  |          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>4 mos.</u>   |  |                   |  |
| 19A. DATE OF OPERATION<br><u>None.</u>   |  |          |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |                   |  |
| 20A. AUTOPSY? (Yes or No)<br><u>NO</u>   |  |          |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |                   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  |          |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |                   |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |          |  | 21D. TIME OF INJURY (APPROX.)   |  |                   |  |
| 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  |          |  | 21F. HOW DID INJURY OCCUR?  |  |                   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10-6</u> 19 <u>69</u> to <u>10-26</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>10-26-12 mid</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |          |  |   |  |                   |  |
| 23A. SIGNATURE<br><u>George S. Ritchie MD</u>  |  |          |  | 23B. DATE SIGNED<br><u>10-26-69</u>   |  |                   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>George F. Ritchie MD</u>  |  |          |  | 23D. ADDRESS<br><u>Montebello State Hosp.</u>   |  |                   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  |          |  | 24B. DATE<br><u>10/29/69</u>  |  |                   |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><u>Moreland Memorial Park</u>  |  |          |  | 24D. LOCATION (City, town, or county) (State)<br><u>Baltimore, Maryland</u>   |  |                   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>OCT 30 1969</u>  |  |          |  | 25B. NAME OF REGISTRAR<br><u>Robert E. Taylor MD</u>  |  |                   |  |
| 25C. FUNERAL DIRECTOR<br><u>Leonard J Ruck Inc. Baltimore, Maryland</u>  |  |          |  | ADDRESS   |  |                   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |                  |   |                                     | REG. NO. <b>69 10639</b>   |
|--|------------------|---|-------------------------------------|--|
| <b>C-140</b>   |                  | <b>69 10639</b>   |                                     | <b>CERTIFICATE OF DEATH</b>  |
| BIRTH NO.  |                  | 1. NAME OF DECEASED<br>(Type or Print) <b>CEFALU, Philip (Filippo)</b>  |                                     | 2. DATE AND HOUR OF DEATH<br><b>OCT 26, 1969 1:20 AM</b>                 |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>44 THE UNION MEMORIAL HOSPITAL</b>   |                  | 4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>2744</b><br>C. CITY OR TOWN <b>BALTIMORE</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>5310 WALTER BLVD.</b> |                                     |  |
| 5. SEX <b>M</b>  | 6. RACE <b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>06-29-90</b> | 9. AGE (In years last birthday) <b>79</b>                                |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Produce Packer ASWP</b>  |                  | 10B. KIND OF BUSINESS OR INDUSTRY   |                                     | 11. BIRTHPLACE (State or foreign country)<br><b>ITALY</b>                |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                  | 13. FATHER'S NAME<br><b>VINCE CEFALU</b>  |                                     |  |
| 14. MOTHER'S MAIDEN NAME<br><b>GLORIA OLSEN</b>  |                  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> <b>WW 1</b>   |                                     |  |
| 16. SOCIAL SECURITY NO.<br><b>219-32-4277</b>  |                  | 17. INFORMANT<br><b>Mrs Rose Cefalu</b>   |                                     |  |
| 18. <b>412.31+162.1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.)<br><b>ASHO &amp; Heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) <b>probable lung cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) _____ |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                                     |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                  |   |                                     |  |
| 19A. DATE OF OPERATION<br><b>0</b>   |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                     | 20A. AUTOPSY? (Yes or No)  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                     | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                                     | 21F. HOW DID INJURY OCCUR?   |
| 22. I certify that (1) (this hospital) attended the deceased from <b>OCT 21</b> 19 <b>69</b> to <b>OCT 26</b> 19 <b>69</b> , that (1) (we) last saw the deceased alive on <b>OCT 26</b> 19 <b>69</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.                                |                  |   |                                     |  |
| 23A. SIGNATURE<br><b>Tzen-chi Fan-chiang</b>   |                  | 23B. DATE SIGNED  |                                     | 23C. PHYSICIAN'S NAME (Type)<br><b>TZEN-CHI FAN-CHIANG</b>               |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                  | 24B. DATE<br><b>10/29/69</b>  |                                     | 24C. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>               |
| 24D. LOCATION<br><b>Baltimore, Maryland</b>  |                  | 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 30 1969</b>   |                                     |  |
| 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>  |                  | 25C. FUNERAL DIRECTOR<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>   |                                     |  |

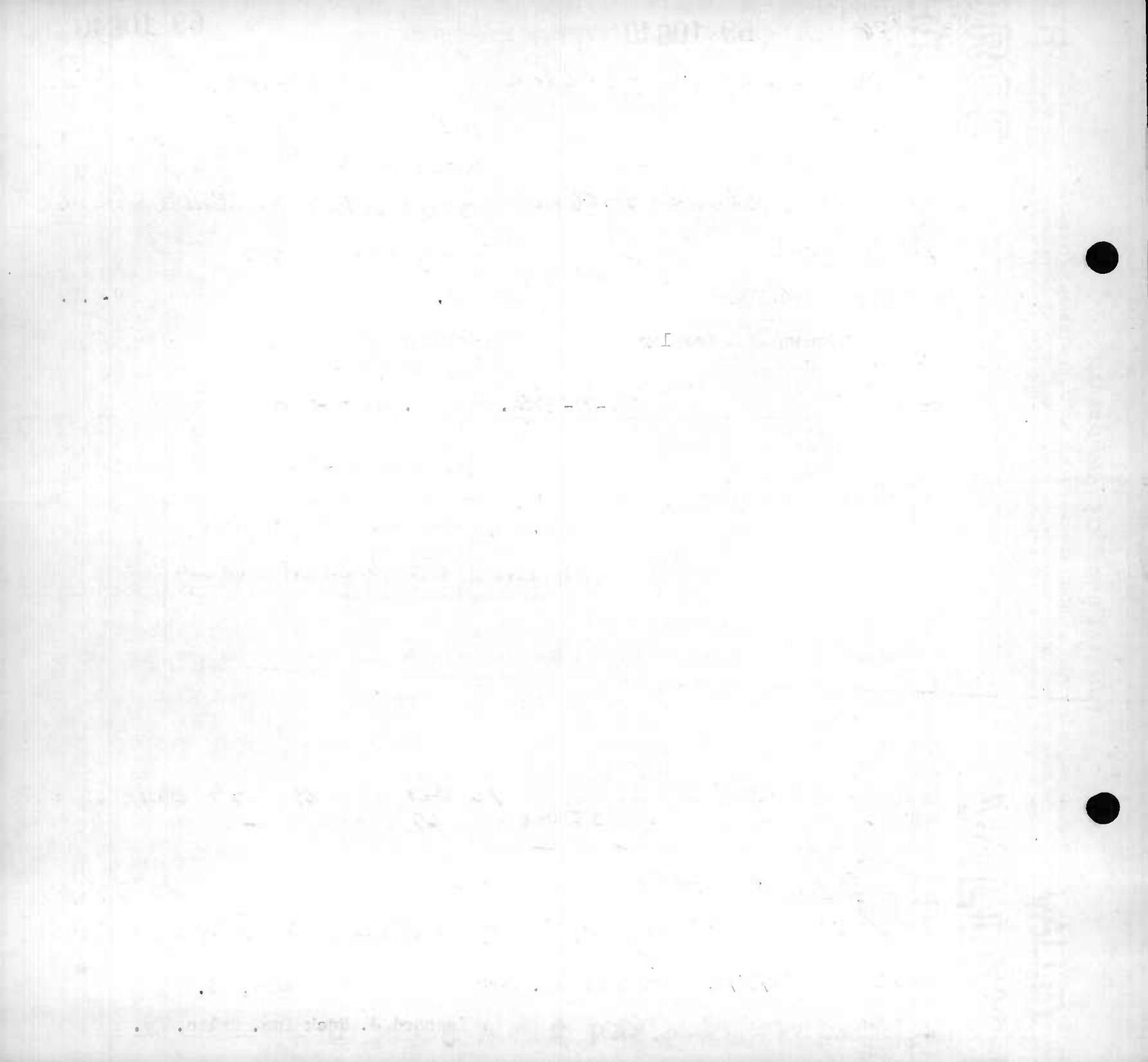
5310 Walther Ave. CT



# FUNERAL DIRECTOR: IMPORTANT

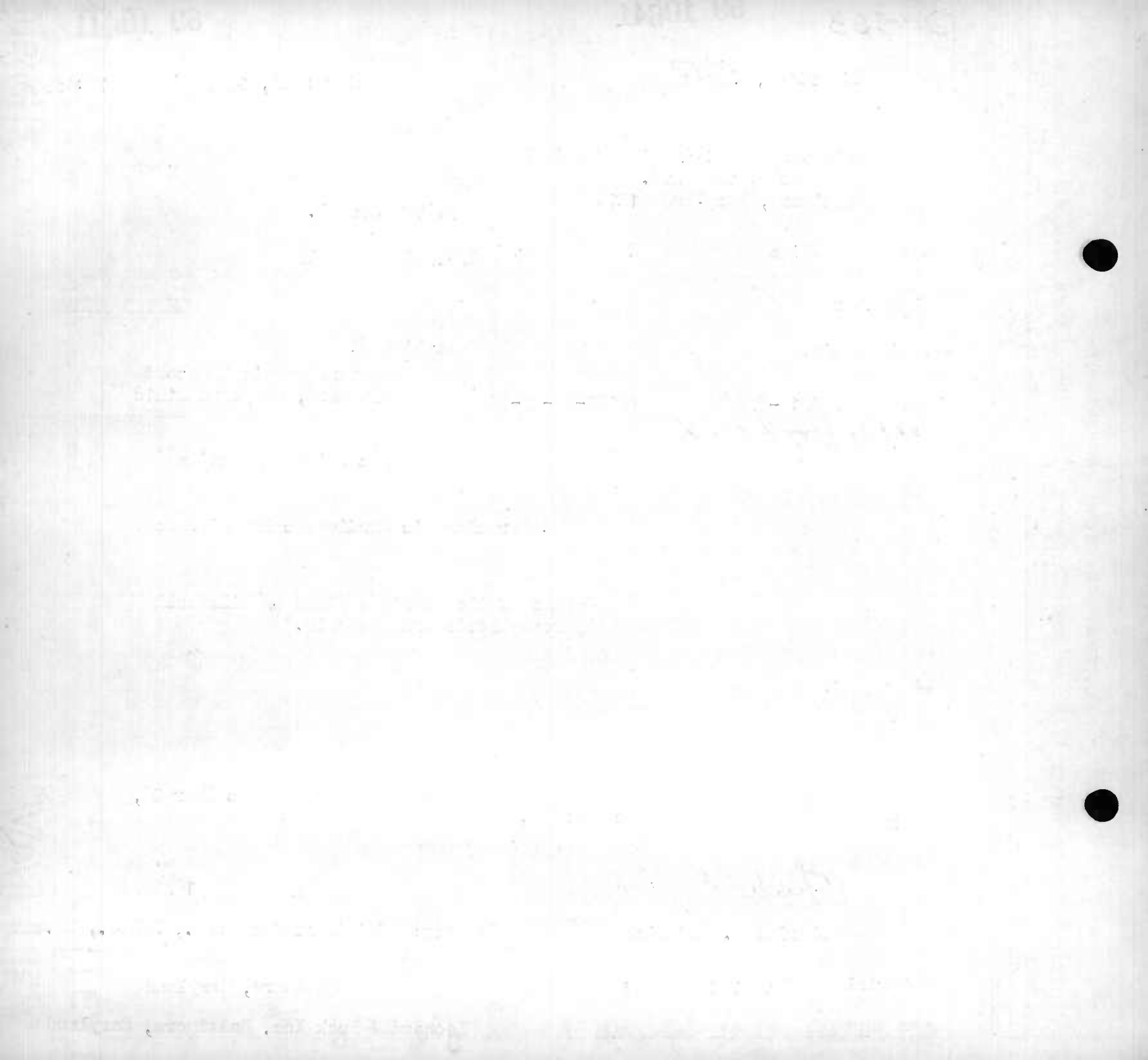
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                      |   |                                    |
|---|----------------------|---|------------------------------------|
| <div style="display: flex; justify-content: space-between;"> <span><b>K-146</b></span> <span><b>69 10640</b></span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <div style="display: flex; justify-content: space-between;"> <span>BIRTH NO.</span> <span><b>69 10640</b></span> <span>REG. NO.</span> </div>  |                      |   |                                    |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Mr. HARRY M Koebler</b>   |                      | 2. DATE AND HOUR OF DEATH<br><b>10-27-69 8:40 a.m.</b>  |                                    |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Gold's Convalescent</b><br><b>906 116 Belair Rd Baltimore</b>   |                      | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD</b> B. COUNTY <b>2744</b><br>C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>3301 White Ave Balto 21214 Md</b> |                                    |
| 5. SEX <b>Male</b>  | 6. RACE <b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <b>2 Aug 1882</b> |
| 9. AGE (In years last birthday) <b>87</b>   |                      | 10. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |                                    |
| 11. BIRTHPLACE (State or foreign country) <b>Md.</b>  |                      | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |                                    |
| 13. FATHER'S NAME <b>Unknown Koebler</b>  |                      | 14. MOTHER'S MAIDEN NAME <b>Unknown</b>   |                                    |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>  |                      | 16. SOCIAL SECURITY NO. <b>162-09-7926A</b>   |                                    |
| 17. INFORMANT <b>Harry C. Knapp - same</b>  |                      | ADDRESS   |                                    |
| 18. <b>412.31</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Atherosclerotic Cardio-vascular Disease - Myocardial Ischemia &amp; Peripheral artery insufficiency.</b>                                    |                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>undet.</b>   |                                    |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                      | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C)   |                                    |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |                      |   |                                    |
| 19A. DATE OF OPERATION <b>0</b>   |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                    |
| 20A. AUTOPSY? (Yes or No)   |                      | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                                    |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                    |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                      | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)   |                                    |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                      | 21F. HOW DID INJURY OCCUR?  |                                    |
| 22. I certify that (I) (this hospital) attended the deceased from <b>16 Oct 19 69</b> to <b>27 Oct 19 69</b> , that (I) <del>was</del> lost saw the deceased alive on <b>25 Oct 19 69</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) (did not) view the body after death. |                      |   |                                    |
| 23A. SIGNATURE <b>John C. Hyle</b>  |                      | 23B. DATE SIGNED <b>10-27-69</b>  |                                    |
| 23C. PHYSICIAN'S NAME (Type) <b>JOHN C. Hyle</b>  |                      | 23D. ADDRESS <b>7527 Belair Rd Balto 21236 Md</b>   |                                    |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>  |                      | 24B. DATE <b>10/30/69</b>   |                                    |
| 24C. NAME OF CEMETERY or CREMATORY <b>Moreland Mem. Park</b>  |                      | 24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>   |                                    |
| 25A. DATE REC'D BY HEALTH DEPT. <b>OCT 30 1969</b>  |                      | 25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>  |                                    |
| 25C. FUNERAL DIRECTOR <b>Leonard J. Hook Inc. Balto. Md.</b>  |                      | ADDRESS   |                                    |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

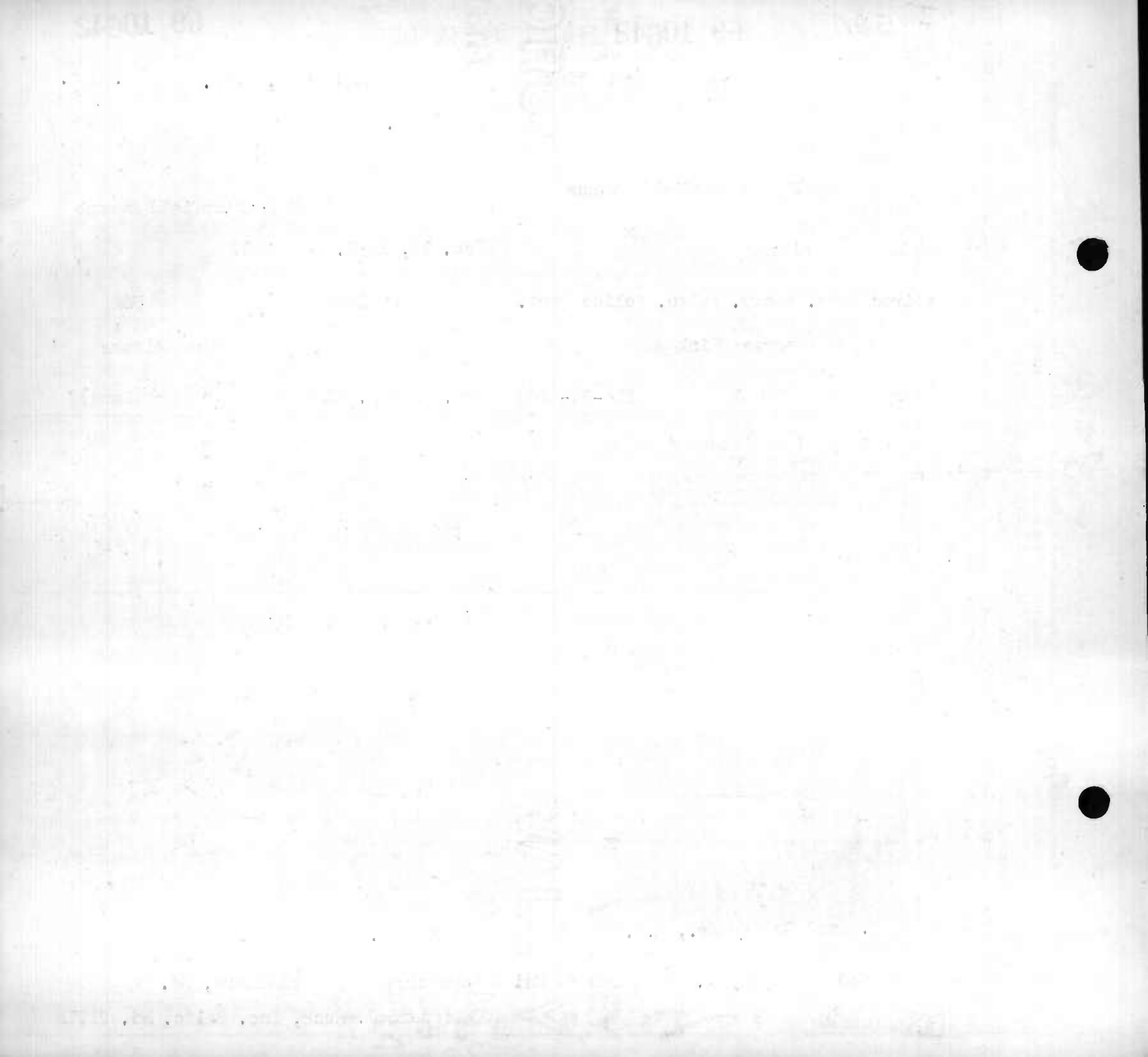
|  |                         |   |  |   |   |   |  |
|--|-------------------------|---|--|---|---|---|--|
| D-563  |                         | 69 10641  |  | BALTIMORE CITY HEALTH DEPARTMENT  |   | REG. NO. 69 10641   |  |
| BIRTH NO.  |                         |   |  |   |   |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Andrew Dimartino, Andrew NMI</b>   |                         |   |  | 2. DATE AND HOUR OF DEATH<br><b>October 26, 1969 10:45 A.M.</b>                       |   |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                         |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |   |   |  |
| FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Veterans Administration Hospital</b>   |                         |   |  | A. STATE <b>MARYLAND</b> B. COUNTY <b>2758</b>  |   |   |  |
| <b>3900 Loch Raven Blvd.</b>   |                         |   |  | C. CITY OR TOWN<br><b>BALTIMORE</b>   |   | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| <b>Baltimore, Maryland 21218</b>   |                         |   |  | E. STREET AND NUMBER<br><b>5707 Nasco Pl.</b>   |   |   |  |
| 5. SEX<br><b>Male</b>  | 6. RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2/25/94</b>               | 9. AGE (In years lost birthday)<br><b>75</b>  | If Under 1 Yr. Months: Days:  | If Under 24 Hrs. Hours: Min.  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Shoemaker</b>  |                         |   | 10B. KIND OF BUSINESS OR INDUSTRY                |   | 11. BIRTHPLACE (State or foreign country)<br><b>ITALY</b>                         |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b> |
| 13. FATHER'S NAME<br><b>Joseph Martino</b>   |                         |   | 14. MOTHER'S MAIDEN NAME<br><b>Josephine ?</b>   |   |   |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes 9/4/18-3/5/19</b>   |                         |   | 16. SOCIAL SECURITY NO.<br><b>PN102-02-25-94</b> |   | 17. INFORMANT <b>Veterans Hospital Record</b><br><b>Baltimore, Maryland 21218</b> |   |  |
| 18. <b>410.941.185X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Acute Myocardial Infarction</b>  |                         |   |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:              |   |   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                         |   |  | (B) <b>Atherosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF:  |   |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                         |   |  | (C) <b>Cancer of the Prostate gland w/ bilateral hydronephrosis and Azotemia.</b>     |   |   |  |
| 19A. DATE OF OPERATION   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>  |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR?  |   | (If in Baltimore City, give exact location)   |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |   |   |  |
| 22. I certify that <del>(x)</del> (this hospital) attended the deceased from <b>September 24, 1969</b> to <b>October 26, 1969</b> , that <del>(x)</del> (we) last saw the deceased alive on <b>October 26, 1969</b> and that in <del>(m)</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>(x)</del> (We) (did) <del>(did not)</del> view the body after death. |                         |   |  |   |   |   |  |
| 23A. SIGNATURE<br><b>Charles E. Defelice</b>   |                         |   |  | 23B. DATE SIGNED<br><b>10/26/69</b>   |   | 23C. PHYSICIAN'S NAME (Type)<br><b>Charles E. Defelice MD</b>                                 |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 24B. DATE<br><b>10/29/69</b>  |  | 24C. NAME of CEMETERY or CREMATORY<br><b>Holy Redeemer</b>                            |   | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>                   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 30 1969</b>  |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor MD</b>  |  | 25C. FUNERAL DIRECTOR<br><b>Leonard J. Ruck Inc. Baltimore, Maryland</b>              |   |   |  |



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

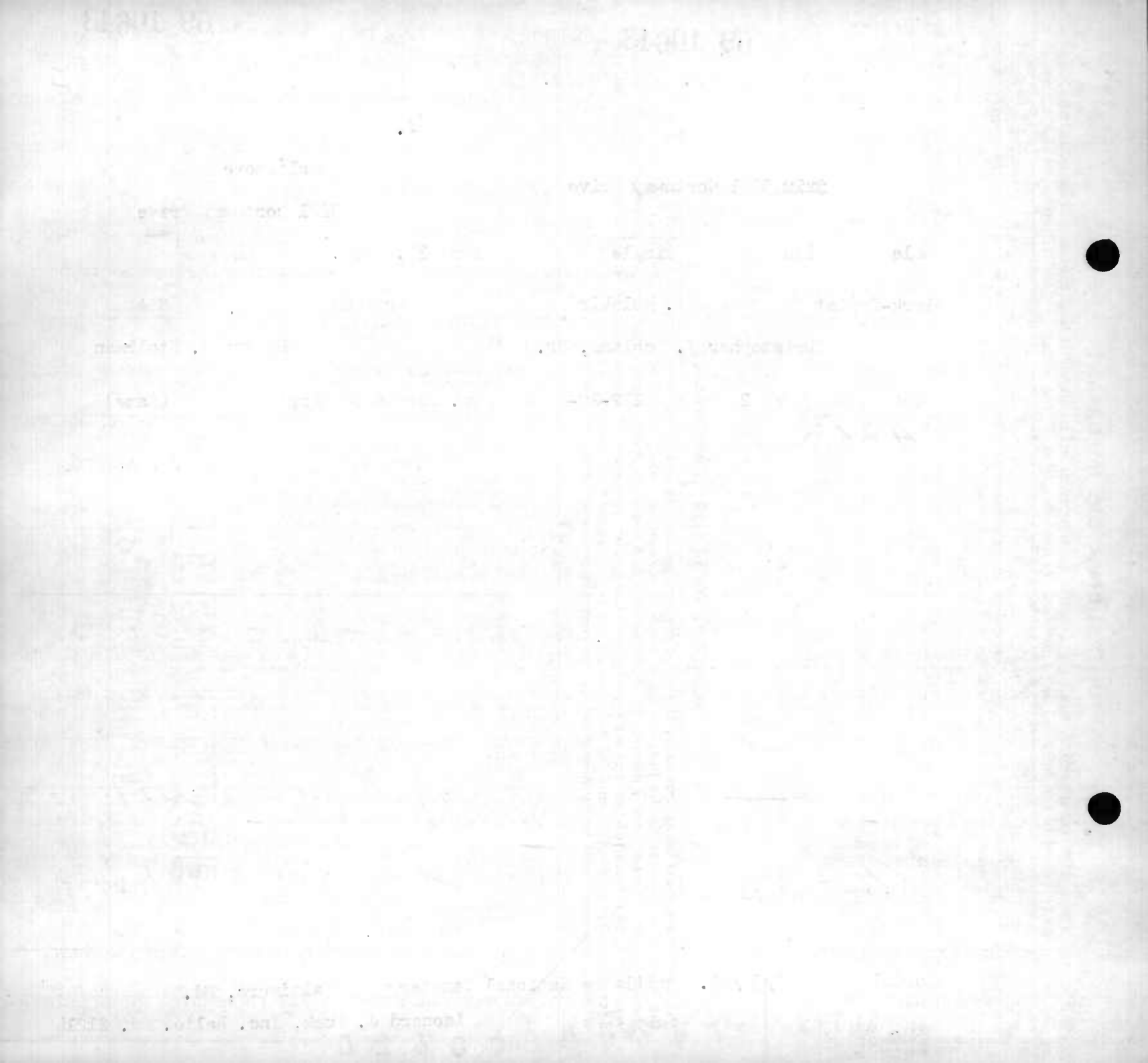
|  |                             |   |  |
|--|-----------------------------|---|--|
| <p><b>F-520</b></p> <p><b>69 10642 CERTIFICATE OF DEATH</b></p>  |                             | <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>REG. NO. <b>69 10642</b></p>   |  |
| <p><b>BIRTH NO.</b></p> <p>1. NAME OF DECEASED<br/>(Type or Print) <b>George Raymond Fink</b></p>  |                             | <p>2. DATE AND HOUR OF DEATH<br/><b>October 27, 1969. 11.00 a.</b></p>  |  |
| <p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br/><b>2827 Chesterfield Avenue</b></p>   |                             | <p>4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br/>A. STATE <b>Md.</b> B. COUNTY <b>831</b></p> <p>C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <b>2827 Chesterfield Avenue</b></p>  |  |
| <p>5. SEX <b>Male</b></p>  | <p>6. RACE <b>White</b></p> | <p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br/>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>   | <p>8. DATE OF BIRTH <b>Feb. 16, 1897.</b></p>  |
| <p>9. AGE (In years last birthday) <b>72</b></p>   |                             | <p>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</p>  | <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br/><b>Retired Exec. Secty. Balto. Police Dept.</b></p> |
| <p>10B. KIND OF BUSINESS OR INDUSTRY</p>   |                             | <p>11. BIRTHPLACE (State or foreign country)<br/><b>Maryland</b></p>  | <p>12. CITIZEN OF WHAT COUNTRY?<br/><b>USA</b></p>   |
| <p>13. FATHER'S NAME<br/><b>George Fink</b></p>  |                             | <p>14. MOTHER'S MAIDEN NAME<br/><b>Florence Leisure</b></p>   |  |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br/><b>Yes W W 1</b></p>   |                             | <p>16. SOCIAL SECURITY NO.<br/><b>216-34-8208</b></p>   | <p>17. INFORMANT<br/><b>Mrs. Mary B. Fink</b></p>  |
| <p>ADDRESS<br/><b>(Same)</b></p>   |                             | <p>18. <b>410.941 250.9</b><br/>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br/>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br/><b>Germany Ocean</b><br/>ANTECEDENT CAUSES<br/>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br/><b>Arteriosclerosis V.D.</b></p> |  |
| <p>CAUSE OF DEATH</p>  |                             | <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br/><b>4 hrs</b><br/><b>10 years</b></p>  |  |
| <p>II<br/>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br/><b>Dichter Immitus</b></p>  |                             |   |  |
| <p>19A. DATE OF OPERATION</p>  |                             | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>   |  |
| <p>20A. AUTOPSY? (Yes or No)</p>   |                             | <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>   |  |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>   |                             | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>   |  |
| <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>  |                             | <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</p>  |  |
| <p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>  |                             | <p>21F. HOW DID INJURY OCCUR?</p>   |  |
| <p>22. I certify that (I) (this hospital) attended the deceased from <b>1962</b> 19 to <b>Oct 27</b> 19 <b>69</b>, that (I) <del>we</del> last saw the deceased alive on <b>10/20</b> 19 <b>69</b> and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>we</del> (did) <del>did not</del> view the body after death.</p> |                             |   |  |
| <p>23A. SIGNATURE<br/><b>E. Paul Coffay Jr., M.D.</b></p>  |                             | <p>23B. DATE SIGNED<br/><b>10/27/69</b></p>   |  |
| <p>23C. PHYSICIAN'S NAME (Type)<br/><b>E. Paul Coffay Jr., M.D.</b></p>  |                             | <p>23D. ADDRESS<br/><b>3100 St. Paul Street</b></p>   |  |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify)<br/><b>Burial</b></p>  |                             | <p>24B. DATE<br/><b>10/31/69.</b></p>   |  |
| <p>24C. NAME OF CEMETERY OR CREMATORY<br/><b>Gardens of Faith Cemetery</b></p>   |                             | <p>24D. LOCATION (City, town, or county) (State)<br/><b>Baltimore, Md.</b></p>  |  |
| <p>25A. DATE REC'D BY HEALTH DEPT.<br/><b>OCT 30 1969</b></p>  |                             | <p>25B. NAME OF REGISTRAR<br/><b>Leonard J. Ruck, Inc.</b></p>  |  |
| <p>25C. FUNERAL DIRECTOR<br/><b>Leonard J. Ruck, Inc.</b></p>  |                             | <p>ADDRESS<br/><b>Balto. Md. 21214</b></p>  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                               |  |   |  |  |
|--|-------------------------------|--|---|--|--|
| 5-452  |                               | BALTIMORE CITY HEALTH DEPARTMENT   |   | Registered No. <b>69 10643</b>   |  |
| BIRTH NO. <b>69 10643</b>  |                               | <b>CERTIFICATE OF DEATH</b>  |   |  |  |
| M.E. CASE NO.  |                               | 1. NAME OF DECEASED<br>(Type or Print) <b>CHRISTOPHER J. SCHLANG, JR.</b>  |   | 2. DATE AND HOUR OF DEATH<br><b>10/28/69 7<sup>00</sup> A.M.</b>               |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |                               | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  |   |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>00 3210 3201 Northway Drive</b>   |                               | A. STATE <b>Md.</b><br>B. COUNTY <b>2735</b>   |   |  |  |
|  |                               | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Baltimore</b>  |   |  |  |
|  |                               | D. STREET ADDRESS (If rural, give location)<br><b>3201 Northway Drive</b>  |   |  |  |
| 5. SEX<br><b>Male</b>  | 6. RACE<br><b>White</b>       | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>Single</b>  | 8. DATE OF BIRTH<br><b>March 22, 1925</b> | 9. AGE (In years last birthday)<br><b>44</b>                                   | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Clerk-Typist</b>   |                               | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Ft. Holabird</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                               | 13. FATHER'S NAME<br><b>Christopher J. Schlang, Sr.</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Bertha M. Stallman</b>                          |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes WW 2</b>  |                               | 16. SOCIAL SECURITY NO.<br><b>212-20-2544</b>  |   | 17. INFORMANT ADDRESS<br><b>Mrs. Bertha Schlang (Same)</b>                     |  |
| 18. <b>428X1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)<br><b>Myocarditis</b>   |                               | CAUSE OF DEATH<br>(A) DUE TO<br>(B) DUE TO<br>(C) DUE TO   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>14 months</b>                           |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                               |  |   |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                               | <b>Acute Upper Respiratory Infection</b>   |   | <b>3 days</b>  |  |
| 19A. DATE OF OPERATION   |                               | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No)  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)  |                               | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)       |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                               | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                    |   | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (the hospital) attended the deceased from <b>9/1/61</b> to <b>10/28/69</b> that (I) (we) lost saw the deceased alive on <b>9/1/61</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (didn't) view the body after death. |                               |  |   |  |  |
| 23A. SIGNATURE<br><b>Albert B. Bradley</b>   |                               | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |   | 23B. DATE SIGNED<br><b>10/28/69</b>  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>ALBERT B. BRADLEY,</b>  |                               | 23D. ADDRESS<br><b>4900 Belair Road 21206</b>  |   |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 24B. DATE<br><b>10/31/69.</b> | 24C. NAME of CEMETERY or CREMATORY<br><b>Baltimore National Cemetery</b>   |   | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>         |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 30 1969</b>  |                               | 25B. NAME OF REGISTRAR<br><b>Robert E. Saylor, R.D.</b>  |   | 25C. FUNERAL DIRECTOR ADDRESS<br><b>Leonard J. Ruck, Inc. Balto. Md. 21214</b> |  |





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

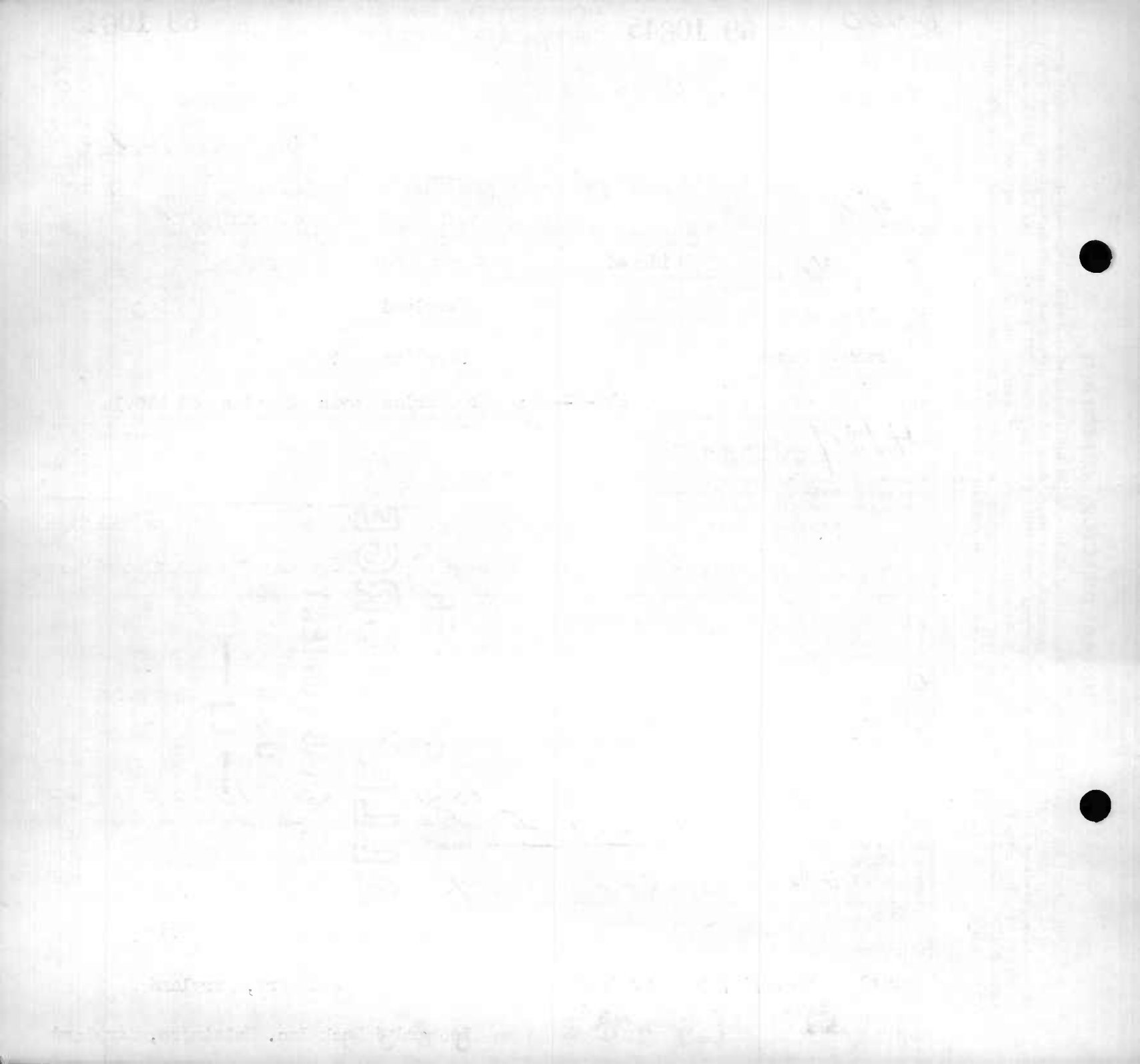
| BALTIMORE CITY HEALTH DEPARTMENT  |   |   |  | REG. NO. <b>69 10644</b>  |
|---|---|---|--|---|
| <b>U-456</b><br><b>BIRTH NO.</b><br><b>1. NAME OF DECEASED</b><br>(Type or Print) <b>Daniel R Ulmer</b>   |   | <b>69 10644</b><br><b>CERTIFICATE OF DEATH</b><br><b>2. DATE AND HOUR OF DEATH</b><br><b>10-24-69</b> <b>7 A</b> M.   |  |   |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><br><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>2553 Perring Manor Road</b><br><b>00</b>  |   | <b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)<br><b>A. STATE</b> <b>Maryland</b> <b>2737</b><br><b>B. COUNTY</b><br><b>C. CITY OR TOWN</b> <b>Baltimore</b><br><b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br><b>E. STREET AND NUMBER</b> <b>2553 Perring Manor Road</b> |  |   |
| <b>5. SEX</b> <b>Male</b><br><b>6. RACE</b> <b>Caucasian</b>  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> | <b>8. DATE OF BIRTH</b> <b>April 30, 25</b><br><b>9. AGE</b> (In years last birthday) <b>44</b><br>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.  |  |   |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Reporter</b>   |   | <b>10B. KIND OF BUSINESS OR INDUSTRY</b><br><b>Sun Papers</b>   |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>Pennsylvania</b>             |
| <b>13. FATHER'S NAME</b><br><b>Daniel C. Ulmer</b>  |   | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>USA</b>   |  |   |
| <b>15. Was Deceased Ever in U. S. Armed Forces?</b><br>(Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes WW II</b>  |   | <b>16. SOCIAL SECURITY NO.</b><br><b>151-14-2828</b>  |  | <b>17. INFORMANT</b><br><b>Mrs. Virginia Ulmer</b><br><b>ADDRESS</b><br><b>Same</b> |
| <b>18. CAUSE OF DEATH</b>   |   |   |  |   |
| <b>I</b><br><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Coronary heart disease 48 years</b><br><b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b><br><b>ANTECEDENT CAUSES</b><br><b>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</b><br><b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b><br><b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b> |   |   |  |   |
| <b>II</b><br><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>  |   |   |  |   |
| <b>19A. DATE OF OPERATION</b><br><b>0</b>   |   | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>   |  | <b>20A. AUTOPSY? (Yes or No)</b><br><b>No</b>                                       |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)  |   | <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)     |
| <b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)  |   | <b>21E. INJURY OCCURRED</b><br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | <b>21F. HOW DID INJURY OCCUR?</b>   |
| <b>22. I certify that (I) (this hospital) attended the deceased from 1967 to Oct. 24 1969, that (I) (we) last saw the deceased alive on Dec. 21 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>   |   |   |  |   |
| <b>23A. SIGNATURE</b><br><b>R Donald Jandorf</b>  |   |   |  | <b>23B. DATE SIGNED</b><br><b>10-24-69</b>  |
| <b>23C. PHYSICIAN'S NAME</b> (Type)<br><b>R Donald Jandorf</b>  |   | <b>23D. ADDRESS</b><br><b>7403 Harford Rd</b>   |  |   |
| <b>24A. BURIAL CREMATION, REMOVAL</b> (Specify)<br><b>Burial</b>  |   | <b>24B. DATE</b><br><b>10/28/69</b>   |  | <b>24C. NAME of CEMETERY or CREMATORY</b><br><b>Baltimore National</b>              |
| <b>24D. LOCATION</b> (City, town, or county) (State)<br><b>Baltimore Maryland</b>   |   | <b>25A. DATE REC'D BY HEALTH DEPT.</b><br><b>OCT 30 1969</b>  |  |   |
| <b>25B. NAME OF REGISTRAR</b><br><b>Robert E. Fisher</b>  |   | <b>25C. FUNERAL DIRECTOR</b><br><b>Leonard J. Ruck Inc. 5305 Harford Rd. 21214</b>  |  |   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

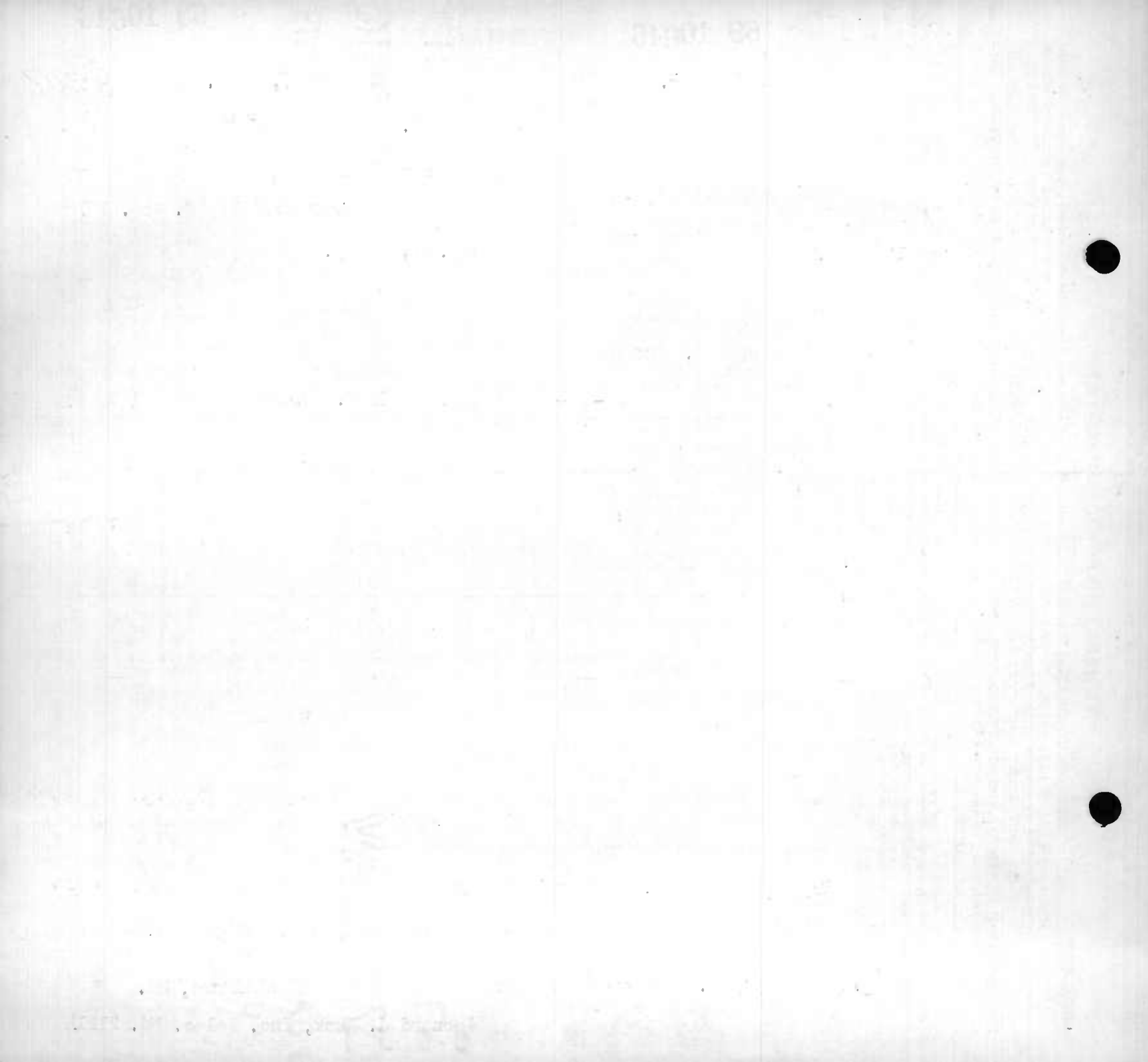
|  |                     |  |  |  |  |   |  |
|--|---------------------|--|--|--|--|---|--|
| BIRTH NO. <b>D-120</b>   |                     | 69 10645   |  | BALTIMORE CITY HEALTH DEPARTMENT<br><b>CERTIFICATE OF DEATH</b>  |  | Registered No. <b>69 10645</b>  |  |
| M.E. CASE NO.  |                     |  |  | 2. DATE AND HOUR OF DEATH  |  |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Mrs. William L. Davis</b>  |                     |  |  | 10-26-69 1 3:40 a.m.   |  |   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |                     |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)  |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>Maryland General Hospital</b><br><b>48</b>   |                     |  |  | A. STATE <b>Balto, Md.</b>   |  |   |  |
|  |                     |  |  | B. COUNTY <b>2642</b>  |  |   |  |
|  |                     |  |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>4245 Balto. city</b>                                   |  |   |  |
|  |                     |  |  | D. STREET ADDRESS (If rural, give location)<br><b>4245 Nicholas Ave.</b>   |  |   |  |
| 5. SEX<br><b>F</b>   | 6. RACE<br><b>W</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>Widowed</b>                             |  | 8. DATE OF BIRTH<br><b>2-5-04</b>  | 9. AGE (In years last birthday)<br><b>65</b> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Waitress</b> |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                     |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  |   |  |
| 13. FATHER'S NAME<br><b>Frank O Puppe</b>  |                     |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Caroline ?</b>  |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                     |  |  | 16. SOCIAL SECURITY NO.<br><b>212-20-0184</b>  |  | 17. INFORMANT ADDRESS<br><b>Mr Charles Davis 2 Malbay Ct 21093</b>  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.)<br><b>410.9 I</b><br><b>Lung Abscess</b>  |                     |  |  | CAUSE OF DEATH   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Several days</b>   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                     |  |  | (A) DUE TO   |  | 2 WEEKS   |  |
|  |                     |  |  | (B) DUE TO   |  | 2 WEEKS   |  |
|  |                     |  |  | (C) DUE TO   |  | 2 WEEKS   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                     |  |  |  |  |   |  |
| 19A. DATE OF OPERATION<br><b>0</b>   |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                     | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10-10-1969</b> to <b>10-26-1969</b> , that (I) (we) last saw the deceased alive on <b>10-25-1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                     |  |  |  |  |   |  |
| 23A. SIGNATURE<br><b>Robert E. Fisher</b>  |                     |  |  | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |  | 23B. DATE SIGNED<br><b>10-26-69</b>   |  |
| 23C. PHYSICIAN'S NAME (Type)   |                     |  |  | 23D. ADDRESS<br><b>Md. General Hospital</b>  |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                     | 24B. DATE<br><b>10/29/69</b>   |  | 24C. NAME of CEMETERY or CREMATORY<br><b>Parkwood</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>                                   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 30 1969</b>  |                     | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher</b>  |  | 25C. FUNERAL DIRECTOR ADDRESS<br><b>Leonard J. Dick Inc. Baltimore, Maryland</b>   |  |   |  |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |  |  |  |                      |  |   |  |   |  | REG. NO. 69 10646  |  |
|--|--|--|--|----------------------|--|---|--|---|--|--|--|
| H-525  |  | 69 10646   |  | CERTIFICATE OF DEATH |  |   |  |   |  |  |  |
| BIRTH NO.  |  | 1. NAME OF DECEASED<br>(Type or Print) CHLORIS E. HANSEN |  |                      |  |   |  | 2. DATE AND HOUR OF DEATH<br>October 27, 1969. 8:30 P.M.  |  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>42 SINAI HOSPITAL   |  |  |  |                      |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Md. B. COUNTY Baltimore 53-00               |  |   |  |  |  |
| 5. SEX Female  |  |  |  |                      |  | 6. RACE White   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>Aug. 11, 1907.                                   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife   |  |  |  |                      |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  |   |  | 9. AGE (In years last birthday) 62                                   |  |
| 13. FATHER'S NAME<br>Robert L. Cooper  |  |  |  |                      |  | 14. MOTHER'S MAIDEN NAME<br>? Cary  |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA                                  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No   |  |  |  |                      |  | 16. SOCIAL SECURITY NO.<br>216-10-4610B   |  | 17. INFORMANT<br>Mr. Carl V. Hansen   |  |  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>410.924 250.9<br>CORONARY OCCLUSION<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br>Diabetes Mellitus |  |  |  |                      |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>Coronary occlusion 2 hr<br>(B) atherosclerosis 10 yr<br>(C) 10 yr |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                         |  |
| 19A. DATE OF OPERATION   |  |  |  |                      |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No) no  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no   |  |  |  |                      |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |  |  |
| 21D. TIME OF INJURY (APPROX.)  |  |  |  |                      |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                     |  | 21F. HOW DID INJURY OCCUR?  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from about 1940 to October 1969, that (I) (we) last saw the deceased alive on 10-17 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |  |  |  |                      |  |   |  |   |  |  |  |
| 23A. SIGNATURE<br>J. DUBER MOORE M.D.  |  |  |  |                      |  | 23B. DATE SIGNED<br>10-28-69  |  |   |  | 23C. PHYSICIAN'S NAME (Type)<br>J. DUBER MOORE M.D.                  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial   |  |  |  |                      |  | 24B. DATE<br>11/1/69.   |  | 24C. NAME OF CEMETERY or CREMATORY<br>Parkwood Cemetery   |  | 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Md.      |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>OCT 30 1969   |  |  |  |                      |  | 25B. NAME OF REGISTRAR<br>J. E. Taylor, Jr.   |  | 25C. FUNERAL DIRECTOR<br>Leonard J. Ruck, Inc. Balto. Md. 21214   |  |  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |  |  |
|---|--|--|--|
| <div style="display: flex; justify-content: space-between;"> <span>69 10647</span> <span>CERTIFICATE OF DEATH</span> </div>   |  | REG. NO. <b>69 10647</b>   |  |
| BIRTH NO. <b>69-19238</b><br>1. NAME OF DECEASED (Type or Print) <b>CROCKER</b>   |  | 2. DATE AND HOUR OF DEATH<br><b>10-23-69</b>   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><b>Church Home and Hospital</b>   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>             |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Church Home and Hospital</b>  |  | C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                              |  |
| 5. SEX <b>male</b> 6. RACE <b>white</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 8. DATE OF BIRTH <b>4-8-28</b> 9. AGE (In years lost birthday) <b>41</b>   |  |
| 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |  |
| 13. FATHER'S NAME <b>Edward Crocker</b>   |  | 14. MOTHER'S MAIDEN NAME <b>Rebecca Long</b>   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT <b>Edward M. V. Khoran</b>  |  | ADDRESS <b>CHH</b>   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>77621</b>  |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <b>respiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF: <b>damage</b>  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 40 hrs</b>  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  | (B) <b>Aspiration due to pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF: <b>-thorax</b>   |  |
| 19A. DATE OF OPERATION <b>0</b>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20A. AUTOPSY? (Yes or No)   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |  |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |
| 23A. SIGNATURE <b>V. Khoran</b>   |  | 23B. DATE SIGNED <b>10-23-69</b>   |  |
| 23C. PHYSICIAN'S NAME (Type)  |  | 23D. ADDRESS   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |  | 24B. DATE <b>10-24-69</b>  |  |
| 24C. NAME OF CEMETERY OR CREMATORY  |  | 24D. LOCATION (City, town, or county) (State)  |  |
| 25A. DATE REC'D BY HEALTH DEPT. <b>OCT 30 1969</b>  |  | 25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>   |  |

**ANATOMY BOARD OF MARYLAND**  
**JOHNS HOPKINS MEDICAL SCHOOL**  
**DEPARTMENT OF MEDICINE - BCHD**

YOUNG MEN'S CHRISTIAN ASSOCIATION  
1001 20th St. N.W.  
WASHINGTON, D.C.



# FUNERAL DIRECTOR: IMPORTANT

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|   |                         |   |  |   |                                 |   |                               |
|---|-------------------------|---|--|---|---------------------------------|---|-------------------------------|
| T-46069-19192   |                         | 69 10648  |  | BALTIMORE CITY HEALTH DEPARTMENT  |                                 | REG. NO. 69 10648   |                               |
| BIRTH NO. <u>Baby Girl Taylor</u>   |                         |   |  | CERTIFICATE OF DEATH  |                                 |   |                               |
| 1. NAME OF DECEASED<br>(Type or Print)  |                         |   |  | 2. DATE AND HOUR OF DEATH<br><u>10/19/69</u> <u>5:15</u> P.M.   |                                 |   |                               |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                         |   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)   |                                 |   |                               |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>Union Memorial Hospital</u>  |                         | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |  | A. STATE<br><u>MD</u>   |                                 | B. COUNTY<br><u>2710</u>  |                               |
|   |                         |   |  | C. CITY OR TOWN<br><u>Balto.</u>  |                                 | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                               |
|   |                         |   |  | E. STREET AND NUMBER<br><u>529 Beaumont Ave.</u>  |                                 |   |                               |
| 5. SEX<br><u>F</u>  | 6. RACE<br><u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>10/18/69</u>   | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months: Days  | 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                         | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)   |                                 | 12. CITIZEN OF WHAT COUNTRY?  |                               |
| 13. FATHER'S NAME<br><u>Retius Taylor</u>   |                         |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Karen Rose Harvell</u>   |                                 |   |                               |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>no</u>   |                         | 16. SOCIAL SECURITY NO.<br><u>—</u>   |  | 17. INFORMANT ADDRESS   |                                 |   |                               |
| 18. <u>776.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   |                         |   |  | CAUSE OF DEATH  |                                 |   |                               |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                         |   |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><u>Pulmonary edema</u>  |                                 |   |                               |
|   |                         |   |  | (B) DUE TO, OR AS A CONSEQUENCE OF:<br><u>M.M.</u>  |                                 |   |                               |
|   |                         |   |  | (C) DUE TO, OR AS A CONSEQUENCE OF:   |                                 |   |                               |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                         |   |  |   |                                 |   |                               |
| 19A. DATE OF OPERATION<br><u>21</u>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY (Yes or No)<br><input checked="" type="checkbox"/>   |                                 | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |                               |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                                 |   |                               |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |                                 |   |                               |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10-18-</u> 19 <u>69</u> to <u>10-19</u> 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>10-19</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |   |  |   |                                 |   |                               |
| 23A. SIGNATURE<br><u>Evelyn P. Navarro</u> 40 DEGREE  |                         |   |  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |                                 | 23B. DATE SIGNED<br><u>10/19/69</u>   |                               |
| 23C. PHYSICIAN'S NAME (Type)<br><u>EVELYN P. NAVARRO</u> 40 DEGREE  |                         |   |  | 23D. ADDRESS<br><u>UNION MEMORIAL HOSPITAL</u>  |                                 |   |                               |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |                         | 24B. DATE<br><u>10-23-69</u>  |  | 24C. NAME OF CEMETERY or ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL (State)  |                                 |   |                               |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>OCT 30 1969</u>   |                         | 25B. NAME OF REGISTRAR<br><u>Robert E. Taylor</u>   |  | 25C. NAME OF DIRECTOR<br><u>MORTUARY SERVICE - BCHD</u>   |                                 |   |                               |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |                     |   |  | REG. NO. <b>69 10649</b>   |   |
|--|---------------------|---|--|--|---|
| B-620<br>69-19983<br>69 10649  |                     | <b>CERTIFICATE OF DEATH</b>   |  |  |   |
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>Baby Boy Briggs</b>   |                     | 2. DATE AND HOUR OF DEATH<br><b>10/18/69 10<sup>42</sup> Am</b>   |  |  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Union Memorial Hosp.</b><br><b>44</b>  |                     | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>2917 Norfolk ave</b> B. COUNTY <b>15-12</b><br>C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>2917 Norfolk ave.</b> |  |  |   |
| 5. SEX<br><b>m</b>   | 6. RACE<br><b>N</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH<br><b>10/18/69</b>  | 9. AGE (In years last birthday)<br><b>6</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>—</b>  |                     | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                         |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |                     | 13. FATHER'S NAME<br><b>Robert Troy Thompson</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Shirley Lee Briggs</b>                                |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>—</b>   |                     | 16. SOCIAL SECURITY NO.<br><b>—</b>   |  | 17. INFORMANT<br><b>Mother</b>   |   |
| 18. <b>748.6 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                     | CAUSE OF DEATH<br><b>Congenital Pulmonary Anomaly &amp; Massive Atelectasis</b><br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>Congenital anomaly</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <b>—</b>  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 hr</b><br><b>M M</b>           |   |
| <b>II</b>  |                     |   |  |  |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                     |   |  |  |   |
| 19A. DATE OF OPERATION<br><b>2/2 none</b>  |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>  |  | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> <b>No</b>              |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)<br><b>—</b>   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>—</b> |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)<br><b>—</b>  |                     | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?<br><b>—</b>   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10/18/69</b> to <b>10/18/69</b> , that (I) (we) last saw the deceased alive on <b>10/18/69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                               |                     |   |  |  |   |
| 23A. SIGNATURE<br><b>Darrell V Lewis</b>   |                     |   |  | 23B. DATE SIGNED<br><b>10/18/69</b>  |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>—</b>   |                     |   |  | 23D. ADDRESS<br><b>Union Memorial Hosp.</b>  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>—</b>   |                     | 24B. DATE<br><b>10-23-69</b>  |  | 24C. NAME OF CEMETERY<br><b>—</b>  |   |
| 24D. LOCATION (City, town, or county)<br><b>—</b>  |                     | 24E. LOCATION (State)<br><b>—</b>   |  |  |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 30 1969</b>  |                     | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor</b>   |  | 25C. FUNERAL DIRECTOR<br><b>MORTUARY SERVICE - BCHD</b>                              |   |

X

2012-2013

2013-2014

2014-2015

X

2015-2016

2016-2017

2017-2018

2018-2019

2019-2020

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Badly burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                        |   |  | REG. NO. <b>69 10650</b>   |  |
|---|------------------------|---|--|--|--|
| G-362 69 10650  |                        | BIRTH NO. <b>69-19226</b>   |  |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>BABY GIRL GATERS</b>  |                        |   | 2. DATE AND HOUR OF DEATH<br><b>10-20-69 9<sup>00</sup> A</b> M.   |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>UNIVERSITY OF MARYLAND HOSPITAL</b>   |                        |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>1603</b>  |  |  |
|   |                        |   | C. CITY OR TOWN <b>BALTIMORE</b>   |  | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|   |                        |   | E. STREET AND NUMBER<br><b>710 N. GILMOR ST.</b>   |  |  |
| 5. SEX<br><b>FEMALE</b>   | 6. RACE<br><b>N. N</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10/17/69</b>  | 9. AGE (In years last birthday)<br><b>-</b>  | If Under 1 Yr. Months: Days: Hours: Min.<br><b>- 2 92 -</b>                                |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>-</b>   |                        | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>  |                        | 13. FATHER'S NAME<br><b>JOHN LEE</b>  |  |  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>JUANITA GATERS</b>   |                        |   |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>-</b> |  |
| 16. SOCIAL SECURITY NO.<br><b>-</b>   |                        | 17. INFORMANT ADDRESS<br><b>-</b>   |  |  |  |
| 18. <b>776.1 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>HYALINE MEMBRANE DISEASE</b><br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.<br><b>PREMATURITY</b> |                        |   | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>HYALINE MEMBRANE DISEASE</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>PREMATURITY</b><br>(C) DUE TO, OR AS A CONSEQUENCE OF:<br><b>-</b> |  |  |
| MEDICAL CERTIFICATION   |                        |   |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>-</b>  |                        |   |  |  |  |
| 19A. DATE OF OPERATION<br><b>2 NONE</b>   |                        | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-</b>  |  | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                        |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                        | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>-</b>  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>-</b>                                 |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)<br><b>-</b>  |                        | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?<br><b>-</b>   |  |
| 22. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>10-17-1969</b> to <b>10-20-1969</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>10-20-1969</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.                           |                        |   |  |  |  |
| 23A. SIGNATURE<br><b>Krita Apibunyopas, M.D.</b>  |                        |   |  | 23B. DATE SIGNED<br><b>10/20/69</b>  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>KRITA APIBUNYOPAS M.D.</b>   |                        |   |  | 23D. ADDRESS<br><b>University of Maryland Hospital, Md.</b>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>10-23-69</b>   |                        | 24B. DATE<br><b>10-23-69</b>  |  | 24C. NAME OF CEMETERY<br><b>ANATOMY BOARD OF MARYLAND</b>  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 30 1969</b>   |                        | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor</b>   |  | 25C. FUNERAL DIRECTOR<br><b>UNIVERSITY MEDICAL SCHOOL</b>  |  |
| 25D. MORTUARY SERVICE - <b>BCHD</b>   |                        |   |  |  |  |

UNIVERSITY OF MASSACHUSETTS  
FEMALE  
JANUARY  
JANUARY  
JANUARY

1900

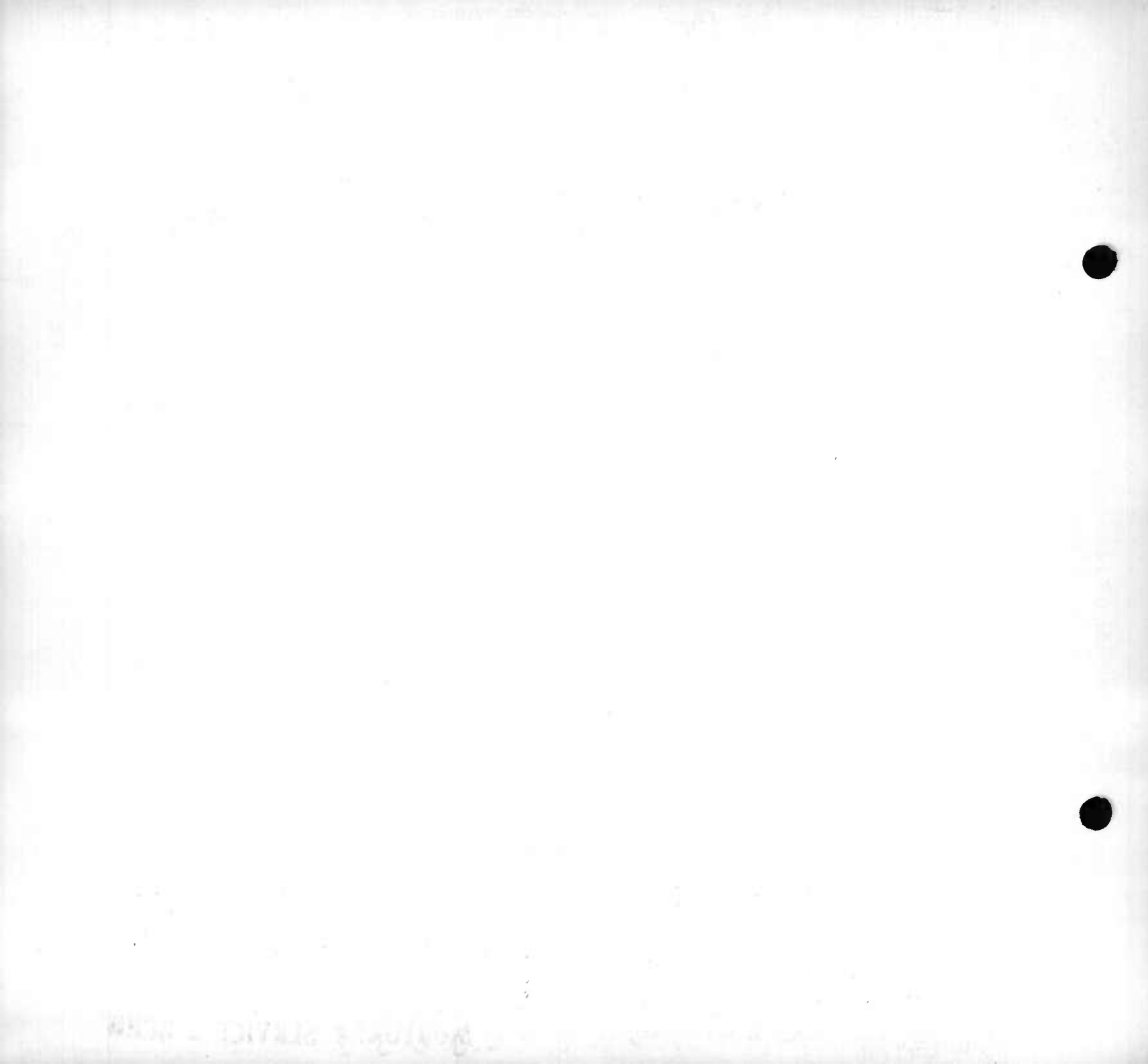
1900  
1900  
1900

1900  
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1900

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| T-655 69 10651   |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | REG. NO. 69 10651  |  |
| BIRTH NO. 109-14221  |  | 1. NAME OF DECEASED (Type or Print) (NB) BABY GIRL THURMAN   |  | 2. DATE AND HOUR OF DEATH 10-18-69 12:15 P.M.  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                  |  | A. STATE & COUNTY MARYLAND 1510  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 8 U of Hospital  |  | C. CITY OR TOWN BALTIMORE  |  | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| E. STREET AND NUMBER 4107 BELVIEW AVE  |  | 5. SEX F   |  | 6. RACE N  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH 10-15-69  |  | 9. AGE (In years last birthday) 3  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country) BALTO. MD  |  |
| 12. CITIZEN OF WHAT COUNTRY? USA   |  | 13. FATHER'S NAME JAMES CHASE  |  | 14. MOTHER'S MAIDEN NAME AGNES THURMAN   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT J R CONDE ADDRESS UNIV. HOSP.  |  |
| 18. 776.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  |  | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hialine Membrane Disease            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days  |  |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  | (B) DUE TO, OR AS A CONSEQUENCE OF:  |  | (C) DUE TO, OR AS A CONSEQUENCE OF:  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  | 19A. DATE OF OPERATION 10-18-69  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                   |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                   |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (1) (this hospital) attended the deceased from October 15 <sup>th</sup> 19 69 to October 18 <sup>th</sup> 19 69 that (1) (we) last saw the deceased alive on October 18 <sup>th</sup> 19 69 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) view the body after death. |  |  |  |  |  |
| 23A. SIGNATURE J.R. Conde, M.D.  |  | 23B. DATE SIGNED October 18, 1969  |  | 23C. PHYSICIAN'S NAME (Type) JOAQUIN RODRIGUEZ CONDE                                       |  |
| 23D. ADDRESS UNIVERSITY OF MARYLAND HOSPITAL   |  | 23E. CITY, STATE, AND COUNTY BALTIMORE, MARYLAND   |  | 23F. ZIP CODE 21201  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) 10-23-69  |  | 24B. DATE  |  | 24C. NAME OF CEMETERY OR CREMATION   |  |
| 25A. DATE REC'D BY HEALTH DEPT. OCT 30 1969  |  | 25B. NAME OF REGISTRAR Robert E. Taylor  |  | 25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHO  |  |

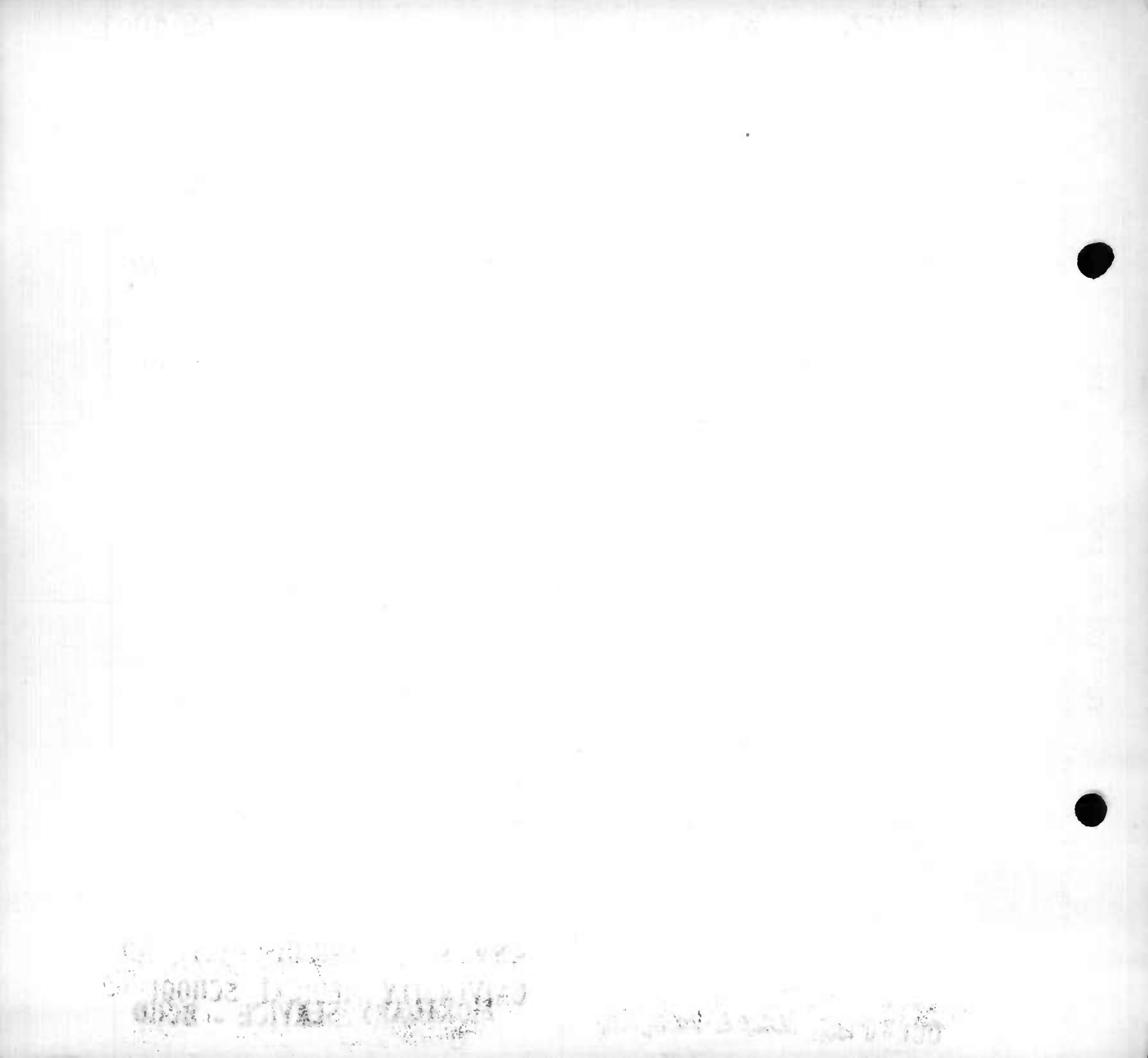




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |
|---|--|
| <div style="display: flex; justify-content: space-between;"> <span><b>2-250</b></span> <span><b>69 10652</b></span> <span><b>BALTIMORE CITY HEALTH DEPARTMENT</b></span> </div> <div style="display: flex; justify-content: space-between;"> <span><b>CERTIFICATE OF DEATH</b></span> <span>REG. NO. <b>69 10652</b></span> </div>  |  |
| <b>BIRTH NO.</b> <u>69-18538</u>  |  |
| <b>1. NAME OF DECEASED</b><br>(Type or Print) <u>Baby Boy Lawson</u>  |  |
| <b>2. DATE AND HOUR OF DEATH</b><br><u>October 11, 69 4:08 A.M.</u>   |  |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><div style="display: flex;"> <div style="flex: 1;"> <b>FULL NAME OF HOSPITAL OR INSTITUTION</b><br/> <u>38 University Hos.</u> </div> <div style="flex: 1;"> <b>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</b><br/> </div> </div>  |  |
| <b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)<br><div style="display: flex;"> <div style="flex: 1;"> <b>A. STATE</b><br/> <u>Baltimore, Maryland</u> </div> <div style="flex: 1;"> <b>B. COUNTY</b><br/> <u>1604</u> </div> </div>   |  |
| <b>5. SEX</b> <u>Male</u>   |  |
| <b>6. RACE</b> <u>N</u>   |  |
| <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/>   |  |
| <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>  |  |
| <b>8. DATE OF BIRTH</b> <u>October 1, 69</u>  |  |
| <b>9. AGE</b> (In years last birthday) <u>10</u>  |  |
| <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>none</u>   |  |
| <b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>  |  |
| <b>12. CITIZEN OF WHAT COUNTRY?</b>   |  |
| <b>13. FATHER'S NAME</b> <u>Alverine Lawson</u>   |  |
| <b>14. MOTHER'S MAIDEN NAME</b> <u>Permelia <del>Lawson</del> Webb</u>  |  |
| <b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)   |  |
| <b>16. SOCIAL SECURITY NO.</b>  |  |
| <b>17. INFORMANT</b> <u>Mother</u>  |  |
| <b>ADDRESS</b> <u>811 N. Monroe St.</u>   |  |
| <b>18. CAUSE OF DEATH</b><br><div style="display: flex;"> <div style="flex: 1;"> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br/>           (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br/> <b>ANTECEDENT CAUSES</b><br/>           DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.         </div> <div style="flex: 1;"> <b>(A) IMMEDIATE CAUSE</b> <u>Prematurity and Hyaline membrane disease</u><br/> <b>DUE TO, OR AS A CONSEQUENCE OF:</b><br/> <b>(B)</b> <u>10 days</u><br/> <b>DUE TO, OR AS A CONSEQUENCE OF:</b><br/> <b>(C)</b> </div> <div style="flex: 1;"> <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> </div> </div> |  |
| <b>II</b><br><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>  |  |
| <b>19A. DATE OF OPERATION</b> <u>2</u>  |  |
| <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>   |  |
| <b>20A. AUTOPSY?</b> (Yes or No) <u>Yes</u>   |  |
| <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>   |  |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner) <input type="checkbox"/>   |  |
| <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  |
| <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)   |  |
| <b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)  |  |
| <b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  |
| <b>21F. HOW DID INJURY OCCUR?</b>   |  |
| <b>22. I certify that</b> (1) (this hospital) attended the deceased from <u>Oct 10, 9:00 PM</u> 19 <u>69</u> to <u>October 11, 4:08 AM</u> 19 <u>69</u> that (1) (we) last saw the deceased alive on <u>4:08 AM, Oct 11</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.   |  |
| <b>23A. SIGNATURE</b> <u>Shih-Wen Huang MD</u>  |  |
| <b>23B. DATE SIGNED</b> <u>October 11, 69</u>   |  |
| <b>23C. PHYSICIAN'S NAME</b> (Type) <u>SHIH-WEN HUANG MD</u>  |  |
| <b>23D. ADDRESS</b>   |  |
| <b>24A. BURIAL CREMATION, REMOVAL (Specify)</b>   |  |
| <b>24B. DATE</b> <u>10-23-69</u>  |  |
| <b>24C. NAME OF CEMETERY OR</b> <u>ANATOMY BOARD OF MARYLAND</u>  |  |
| <b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>OCT 30 1969</u>   |  |
| <b>25B. NAME OF REGISTRAR</b> <u>Robert E. Baker, M.D.</u>  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |                      |  |                                     | REG. NO. <b>69 10653</b>  |   |
|--|----------------------|--|-------------------------------------|---|---|
| <div style="display: flex; justify-content: space-between;"> <span><b>C-516</b></span> <span><b>69 10653</b></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>  |                      |  |                                     |   |   |
| BIRTH NO. <b>69-18441</b>  |                      | 1. NAME OF DECEASED<br>(Type or Print) <b>Baby Girl Chambers</b>   |                                     |   |   |
| 2. DATE AND HOUR OF DEATH<br><b>OCT. 10 1969 3:40 P.M.</b>   |                      | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                                     |   |   |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD</b> B. COUNTY <b>101</b>   |                      | FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>Lutheran Hospital of Md.</b>                                   |                                     |   |   |
| C. CITY OR TOWN <b>Baltimore</b>   |                      | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                     |   |   |
| E. STREET AND NUMBER<br><b>1109<sup>th</sup> Potomac St</b>  |                      |  |                                     |   |   |
| 5. SEX <b>F</b>  | 6. RACE <b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                               | 8. DATE OF BIRTH<br><b>10.10.69</b> | 9. AGE (In years lost birthday)<br><b>14hr.</b>                                       | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                      | 10B. KIND OF BUSINESS OR INDUSTRY  |                                     | 11. BIRTHPLACE (State or foreign country)<br><b>MD</b>                                |   |
| 12. CITIZEN OF WHAT COUNTRY?   |                      | 13. FATHER'S NAME<br><b>???</b>  |                                     |   |   |
| 14. MOTHER'S MAIDEN NAME<br><b>JOAN CHAMBERS</b>   |                      | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |                                     |   |   |
| 16. SOCIAL SECURITY NO.  |                      | 17. INFORMANT ADDRESS  |                                     |   |   |
| 18. <b>776.1 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Myeloid leukemia</b>  |                      | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>Myeloid leukemia</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF: |                                     |   |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                      |  |                                     |   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                      |  |                                     |   |   |
| 19A. DATE OF OPERATION<br><b>10/27/69</b>  |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Autopsy</b>   |                                     | 20A. AUTOPSY? (Yes or No) <b>YES</b>  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                                     | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                      | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                                     | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) lost saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. |                      |  |                                     |   |   |
| 23A. SIGNATURE<br><b>M. J. Kook</b>  |                      | 23B. DATE SIGNED   |                                     | 23C. PHYSICIAN'S NAME (Type)<br><b>MIN JA KOOK</b>                                    |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |                      | 24B. DATE<br><b>10-27-69</b>   |                                     | 24C. NAME OF CEMETERY or other place of interment<br><b>ANATOMY BOARD OF MARYLAND</b> |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 30 1969</b>  |                      | 25B. NAME OF REGISTRAR<br><b>John E. Taylor</b>  |                                     | 25C. NAME OF DIRECTOR<br><b>UNIVERSITY MEDICAL SCHOOL</b>                             |   |
| 25D. ADDRESS<br><b>MORTUARY SERVICE - BCHD</b>   |                      |  |                                     |   |   |

1951

WALTON

1951

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

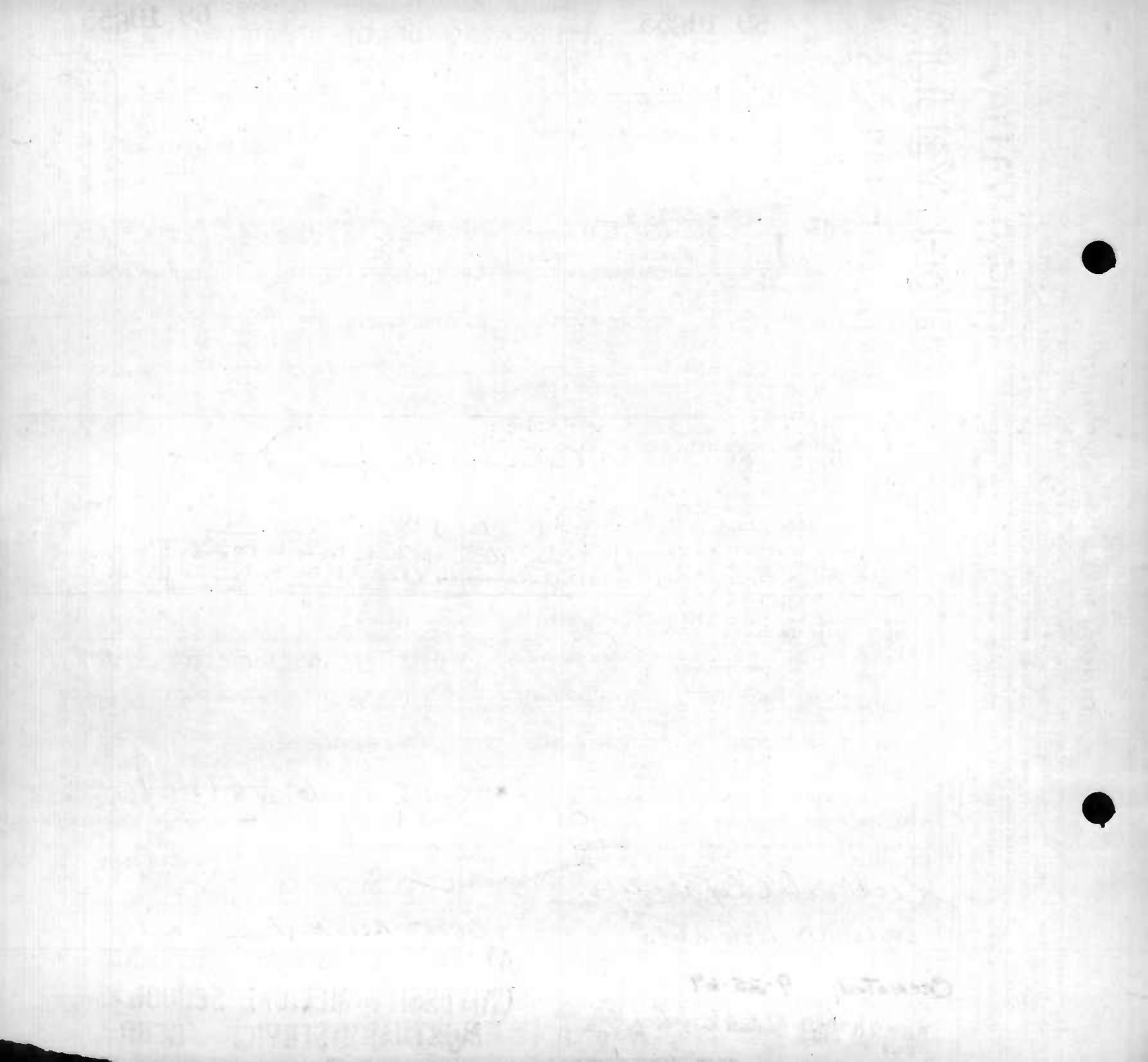
| BALTIMORE CITY HEALTH DEPARTMENT  |  |   |  | REG. NO. 69 10654   |  |
|---|--|---|--|---|--|
| BIRTH NO. 69-19237  |  | 69 10654  |  | X   |  |
| 1. NAME OF DECEASED<br>(Type or Print) Kolb baby boy  |  | 2. DATE AND HOUR OF DEATH<br>9:15 P.M. 10-24-69 10-24-69 M.   |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                     |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>Church Home and Hospital  |  | IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION  |  | A. STATE<br>members in C.H.H.   |  |
| 5. SEX<br>male  |  | 6. RACE<br>white  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 8. DATE OF BIRTH<br>10-24-69  |  |
| 13. FATHER'S NAME<br>Alford Kolb  |  | 14. MOTHER'S MAIDEN NAME<br>Gloria Berz   |  | 9. AGE (In years last birthday)<br>1 34 10  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br>Dr. V. Horvich   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)   |  | CAUSE OF DEATH  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  | (A) IMMEDIATE CAUSE<br>cerebral damage<br>respiratory - failure because of Hypoxia - respiratory acidosis |  | 28 10/60 hours  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |  | (B) DUE TO, OR AS A CONSEQUENCE OF:<br>prematurity (21 lbs 9 g)   |  | 28 10/60 hours  |  |
| 19A. DATE OF OPERATION  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |
| 21D. TIME OF INJURY (APPROX.)   |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 8:08 P.M. 10-23-69 to 9:15 P.M. 10-24-69 that (I) (we) last saw the deceased alive on 9:15 P.M. 10-24-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |   |  |   |  |
| 23A. SIGNATURE<br>V. Horvich  |  | 23B. DATE SIGNED<br>10-24-69  |  | 23C. PHYSICIAN'S NAME (Type)<br>F.J. HELDRICH   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |  | 24B. DATE<br>10-28-69   |  | 24C. NAME of CEMETERY<br>CHURCH HOME HOSPITAL   |  |
| 25A. DATE REC'D BY HEALTH DEPT.   |  | 25B. NAME OF REGISTRAR<br>Robert E. Zuber, M.D.   |  | 25C. ADDRESS<br>ANATOMY BOARD OF MARYLAND<br>JOHN HOPKINS MEDICAL SCHOOL<br>MORTUARY SERVICE - BCHD   |  |

503 to nfield Rd. ⑦  
Gppatoun, n.d.

# FUNERAL DIRECTOR: IMPORTANT

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|  |  |   |  |   |  |
|--|--|---|--|---|--|
| A-223 69 10655   |  | BALTIMORE CITY HEALTH DEPARTMENT<br><b>CERTIFICATE OF DEATH</b>   |  | REG. NO. 69 10655   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Harry A Costa</i>  |  | 2. DATE AND HOUR OF DEATH<br><i>8-23-69 1:15 PM</i>   |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <i>MD</i> B. COUNTY <i>BALTO</i>  |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>90 Mt Sinai Nursing Home</i>  |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |  | C. CITY OR TOWN <i>Balto</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| E. STREET AND NUMBER   |  | 5. SEX <i>M</i> 6. RACE <i>W</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 8. DATE OF BIRTH <i>9-1-1916</i> 9. AGE (In years last birthday) <i>53</i>  |  |
| 11. BIRTHPLACE (State or foreign country)  |  | 12. CITIZEN OF WHAT COUNTRY?  |  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.   |  |
| 13. FATHER'S NAME  |  | 14. MOTHER'S MAIDEN NAME  |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                |  |
| 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | ADDRESS   |  |
| 18. <i>141.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  |  | CAUSE OF DEATH<br><i>Coronary Arteriosclerosis</i><br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |  | (B) <i>Generalized Carcinomatous Metastases</i><br>DUE TO, OR AS A CONSEQUENCE OF:  |  |   |  |
| (C) <i>Squamous Cell Carcinoma of Tongue - Primary</i>   |  |   |  |   |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |   |  |   |  |
| 19A. DATE OF OPERATION   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |
| 21D. TIME OF INJURY (APPROX.)  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Aug 18 1969</i> to <i>8/24/69</i> 19 <i>69</i> and that (I) (we) lost saw the deceased alive on <i>8/24 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |   |  |   |  |
| 23A. SIGNATURE<br><i>William Appleford</i>   |  | 23B. DATE SIGNED  |  | 23C. PHYSICIAN'S NAME (Type)<br><i>William Appleford</i>  |  |
| 23D. ADDRESS<br><i>6615 Rustington Rd</i>  |  | 23E. CITY OR TOWN   |  | 23F. STATE  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>CREMATED</i>  |  | 24B. DATE<br><i>9-25-69</i>   |  | 24C. NAME OF CEMETERY or ANATOMY BOARD OF MARYLAND (City, town, or county) (State)                                      |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>09-20-1969</i>   |  | 25B. NAME OF REGISTRAR<br><i>Robert E. Taylor</i>   |  | 25C. FUNERAL DIRECTOR'S ADDRESS<br><b>UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD</b>                             |  |





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|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| C-626  |  | 69 10656   |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. 69 10656  |  |
| BIRTH NO. CROCKER  |  |  |  | 1. NAME OF DECEASED CROCKER MR. ERNEST  |  |  |  |
| 2. DATE AND HOUR OF DEATH 10-13-69 5:00 PM   |  |  |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  |  |  |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE Md. B. COUNTY BALTIMORE  |  |  |  | FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>MARYLAND GENERAL HOSPITAL                      |  |  |  |
| C. CITY OR TOWN BALTIMORE  |  |  |  | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| E. STREET AND NUMBER 1323 N. CALVERT STREET  |  |  |  |   |  |  |  |
| 5. SEX MALE  |  | 6. RACE CAUCASIAN  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH 09-01-02  |  |
| 9. AGE (in years last birthday) 67   |  | 10. UNDER 1 Yr. Months Days  |  | 11. UNDER 24 Hrs. Hours Min.  |  | 12. CITIZEN OF WHAT COUNTRY? U.S.                                    |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |  |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13. FATHER'S NAME  |  |  |  | 14. MOTHER'S MAIDEN NAME  |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |  |  |  | 16. SOCIAL SECURITY NO. 249-26-4315   |  |  |  |
| 17. INFORMANT  |  |  |  | ADDRESS   |  |  |  |
| 18. CAUSE OF DEATH   |  |  |  |   |  |  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) state the UNDERLYING CONDITION last. |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                         |  |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Septicemia   |  |  |  |   |  | 11 days  |  |
| (B) DUE TO, OR AS A CONSEQUENCE OF: Acute prostatitis  |  |  |  |   |  | 11+ days   |  |
| (C) DUE TO, OR AS A CONSEQUENCE OF: Subdural Hematoma Bilat.   |  |  |  |   |  | 11+ days   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE FATAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |  |  |  |   |  |  |  |
| 19A. DATE OF OPERATION 2   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No) YES   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Unknown       |  | 21C. WHERE DID INJURY OCCUR? Unknown  |  | (If in Baltimore City, give exact location)                          |  |
| 21D. TIME OF INJURY (APPROX.) Unknown  |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR? Unknown  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 10/30/69 19 to 10/13/69 19<br>that (I) (we) last saw the deceased alive on 10/13 19 69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.              |  |  |  |   |  |  |  |
| 23A. SIGNATURE M. Troner M.D.  |  |  |  | 23B. DATE SIGNED 10/13/69   |  | 23C. PHYSICIAN'S NAME (Type)   |  |
| 23D. ADDRESS   |  |  |  | 23E. PHYSICIAN'S ADDRESS  |  | 23F. PHYSICIAN'S ADDRESS   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |  | 24B. DATE 10-23-69   |  | 24C. NAME OF CEMETERY OR INTERMENT PLACE  |  | 24D. ADDRESS   |  |
| 25A. DATE REC'D BY HEALTH DEPT.  |  | 25B. NAME OF REGISTRAR   |  | 25C. FUNERAL DIRECTOR   |  | 25D. ADDRESS   |  |

OCT 30 1969

ANATOMY BOARD OF MARYLAND  
UNIVERSITY MEDICAL SCHOOL  
MORTUARY SERVICE - BCHD

Highway  
11.8 mi

NOT FOR SALE - BCD  
1000

W-460

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 10657

BIRTH NO.

|  |  |  |  |
|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>WILLIE WHEELER</b>   |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>September</b> Day <b>11</b> Year <b>1969</b> Hour <b></b> M. <b></b>   |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) (DOA)<br><b>Loch Raven Vet. A. Hospital</b>  |  | 3. DATE PRONOUNCED DEAD<br>Month <b>September</b> Day <b>11</b> Year <b>1969</b> Hour <b>4:45</b> A. <b>M.</b>   |  |
| 6. SEX<br><b>Male</b>  |  | 7. RACE<br><b>Negro</b>  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>2101</b>  |  |
| 9. DATE OF BIRTH   |  | 10. AGE (In years lost birthday)<br><b>88</b>  |  |
| 11. BIRTHPLACE (State or foreign country)  |  | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 14B. KIND OF BUSINESS OR INDUSTRY  |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  |  | 17. SOCIAL SECURITY NO.  |  |
| 19. <b>412.4</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                  |  | CAUSE OF DEATH<br><b>Arteriosclerotic cardiovascular disease</b><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) _____<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) _____  |  |
| 20A. DATE OF OPERATION   |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br><br>ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b><br>EXAMINER'S NAME (Type)<br><b>Charles S. Springate, M.D.</b> |  | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><br>22F. HOW DID INJURY OCCUR?<br><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>CREMATED</b>  |  | 24B. DATE<br><b>9-25-69</b>  |  |
| 24C. NAME OF CEMETERY<br><b>ANATOMY BOARD OF MARYLAND</b>  |  | 24D. NAME OF CEMETERY<br><b>UNIVERSITY MEDICAL SCHOOL</b>  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 30 1969</b>  |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, Jr.</b>   |  |
| 25C. FUNERAL DIRECTOR<br><b>HOSPITAL DISPOSAL</b>  |  | DATE SIGNED<br><b>September 11, 1969</b>   |  |

1933

UNIVERSITY MEDICAL SCHOOL

9-22-29

WALTER H. HORTON

413.4

S-320

69 10658

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 10658

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

FRANKLIN SCHEETS

2. DATE  
OF  
DEATHKnown ☐  
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

00 1608 Ellsworth Street (DOA)

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

A.

September 3, 1969

10:15 A.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

807

6. SEX

Male

7. RACE

White

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

10. AGE (In years  
lost birthday)

50 78

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

1608 Ellsworth Street

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Cremated

24B. DATE

9-25-69

24C. NAME OF CEMETERY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

OCT 30 1969

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

ANATOMY BOARD OF MARYLAND  
UNIVERSITY MEDICAL SCHOOL  
HOSPITAL DISPOSAL

20-42

11/24

*Paul Walker*

Received 9-25-69

WALLEY FORGE

1  
M-252

69 10659

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 10659

BIRTH NO.

|   |                      |  |   |
|---|----------------------|--|---|
| 1. NAME OF DECEASED <u>JOSEPH LEE</u><br>(Type or Print) <u>James McKnight</u>  |                      | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> 8 30 69 6:10 a. M.          |   |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>Maryland General Hospital 5-15-70</u> |                      | 3. DATE PRONOUNCED DEAD Month Day Year Hour<br>8 30 69 6:10 a. M.  |   |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>Maryland</u> B. COUNTY <u>1205</u>   |                      | C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                                 |   |
| 6. SEX <u>male</u>  | 7. RACE <u>white</u> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | E. STREET AND NUMBER <u>1629 St. Paul St.</u> |
| 9. DATE OF BIRTH 10. AGE (In years lost birthday) <u>44</u><br>If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.   |                      | 11. BIRTHPLACE (State or foreign country)  |   |
| 12. CITIZEN OF WHAT COUNTRY?  |                      | 13. FATHER'S NAME  |   |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                      | 15. MOTHER'S MAIDEN NAME   |   |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)   |                      | 17. SOCIAL SECURITY NO.  |   |
| 18. INFORMANT   |                      | ADDRESS  |   |

|  |   |  |   |
|--|---|--|---|
| MEDICAL CERTIFICATION                                    | 19. <u>E965X1</u> CAUSE OF DEATH  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
|  | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  |  | (A) IMMEDIATE CAUSE <u>Shot gun wound of abdomen</u><br>DUE TO, OR AS A CONSEQUENCE OF:   |
|  | ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |  | (B) DUE TO, OR AS A CONSEQUENCE OF:   |
|  | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |  | (C) DUE TO, OR AS A CONSEQUENCE OF:   |
|  | 20A. DATE OF OPERATION <u>9-25-69</u> 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 21. AUTOPSY? (Yes or No)<br><u>Partial</u><br><u>yes</u>  |
|  | 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><u>home</u>   |
|  | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br><u>1629 St. Paul St. 1205</u>   |  | 22D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY (APPROX.)<br>8 30 69 5:38 a. m.  |
|  | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | 22F. HOW DID INJURY OCCUR?<br><u>shot during altercation</u>  |
|  | 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Partial Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |
|  | ACTUAL SIGNATURE <u>Werner U. Spitz, M.D.</u><br>EXAMINER'S NAME (Type) <u>Werner U. Spitz, M.D.</u>  |  | DATE SIGNED <u>8/31/69</u>  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremated</u> |   | 24B. DATE <u>9-25-69</u>                             |   |
| 24C. NAME OF CEMETERY <u>ANATOMY BOARD OF MARYLAND</u>   |   | 24D. LOCATION (City, town or county) (State)         |   |
| 25A. DATE REC'D BY HEALTH DEPT. <u>OCT 30 1969</u>       |   | 25B. NAME OF REGISTRAR <u>Robert E. Fisher, R.D.</u> |   |
| 25C. NAME OF DIRECTOR <u>UNIVERSITY MEDICAL SCHOOL</u>   |   | 25D. NAME OF DISPOSAL <u>HOSPITAL DISPOSAL</u>       |   |



Quoted 5-22-70

ADENY BOND



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |                     |   |                                   | REG. NO. <b>69 10660</b>   |   |
|--|---------------------|---|-----------------------------------|--|---|
| B-252  |                     | 69 10660  |                                   | CERTIFICATE OF DEATH   |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Winnie E. Buckmaster</b>   |                     | 2. DATE AND HOUR OF DEATH<br><b>10/12/69</b> <b>6 35</b> <b>AM</b>  |                                   |  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                     | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD</b> B. COUNTY <b>ANNE ARUNDEL</b>                   |                                   |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Century Home</b><br><b>102 N. Paca St.</b>  |                     | C. CITY OR TOWN   |                                   | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                      |   |
| E. STREET AND NUMBER   |                     |   |                                   |  |   |
| 5. SEX<br><b>F</b>   | 6. RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1/6/86</b> | 9. AGE (In years last birthday)<br><b>83</b>   | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                     | 10B. KIND OF BUSINESS OR INDUSTRY   |                                   | 11. BIRTHPLACE (State or foreign country)  |   |
| 12. CITIZEN OF WHAT COUNTRY?   |                     | 13. FATHER'S NAME   |                                   |  |   |
| 14. MOTHER'S MAIDEN NAME   |                     | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |                                   |  |   |
| 16. SOCIAL SECURITY NO.<br><b>219-07-8796</b>  |                     | 17. INFORMANT ADDRESS   |                                   |  |   |
| 18. <b>412.41</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)<br><b>Cardio-Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Arteriosclerotic CVD</b><br>(B) <b>Gen + Cerebral Arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Terrific Pneumonia</b> |                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                                   |  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                     |   |                                   |  |   |
| 19A. DATE OF OPERATION<br><b>0</b>   |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                   | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                                   | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>July 14 1969</b> to <b>Oct 12 1969</b> , that (I) (we) last saw the deceased alive on <b>Oct 12 1969</b> and that in (my) <del>last</del> opinion death occurred on the date and hour and from the causes stated above. (I) (We) <del>did</del> (did not) view the body after death.  |                     |   |                                   |  |   |
| 23A. SIGNATURE<br><b>Willard Applefeld</b>   |                     | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>                             |                                   | 23B. DATE SIGNED   |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Willard Applefeld</b>   |                     | 23D. ADDRESS<br><b>1615 Reisterstown Rd</b>   |                                   |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Cremated</b>  |                     | 24B. DATE<br><b>10-15-69</b>  |                                   | 24C. NAME OF CEMETERY<br><b>ANATOMY BOARD OF MARYLAND</b>  |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 30 1969</b>  |                     | 25B. NAME OF REGISTRAR<br><b>240 E. 3rd St.</b>   |                                   | 25C. FUNERAL DIRECTOR<br><b>UNIVERSITY MEDICAL SCHOOL HOSPITAL DISPOSAL</b>  |   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |  |  |   | REG. NO. <b>69 10661</b>   |
|--|--|--|---|--|
| C-400  |  | 69 10661   |   | CERTIFICATE OF DEATH   |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Clay, Jimmie</i>   |  | 2. DATE AND HOUR OF DEATH<br><i>9-17-69 10:15 PM</i>   |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY <i>1802</i>  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><i>Lincoln Memorial Hsp. Home</i><br><i>27 N. Cary Street</i>   |  | C. CITY OR TOWN<br><i>Baltimore</i>  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 5. SEX<br><i>Male</i>  |  | 6. RACE<br><i>Negro</i>  |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Unknown</i>  |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Unknown</i>  |   | 8. DATE OF BIRTH<br><i>8/11/81</i>   |
| 13. FATHER'S NAME<br><i>Henry Clay</i>   |  | 14. MOTHER'S MAIDEN NAME<br><i>Queen Curtis</i>  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO.<br><i>065 218-16-0873 A</i>  |   | 9. AGE (In years last birthday)<br><i>88</i>   |
| 11. BIRTHPLACE (State or foreign country)<br><i>Unknown</i>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U. S. A.</i>  |   |  |
| 17. INFORMANT  |  | ADDRESS  |   |  |
| 18. <i>412-3</i> I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><i>Coronary Artery Disease</i><br><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) DUE TO, OR AS A CONSEQUENCE OF: |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |  |   |  |
| 19A. DATE OF OPERATION   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No) <i>No</i>  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |
| 21D. TIME OF INJURY (APPROX.)  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |   | 21F. HOW DID INJURY OCCUR?   |
| 22. I certify that (I) (this hospital) attended the deceased from <i>2-27-1968</i> to <i>9-17-1969</i> , that (I) (we) last saw the deceased alive on <i>9-17-1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                          |  |  |   |  |
| 23A. SIGNATURE<br><i>[Signature]</i>   |  | 23B. DATE SIGNED<br><i>9-17-69</i>   |   | 23C. PHYSICIAN'S NAME (Type)<br><i>[Signature]</i>   |
| 23D. ADDRESS   |  | 23E. FUNERAL DIRECTOR'S ADDRESS  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Cremated</i>  |  | 24B. DATE<br><i>10-15-69</i>   |   | 24C. NAME OF CEMETERY or CREMATOR<br><i>ANATOMY BOARD OF MARYLAND</i>  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>OCT 30 1969</i>  |  | 25B. NAME OF REGISTRAR<br><i>Robert E. [Signature]</i>   |   | 25C. FUNERAL DIRECTOR'S ADDRESS<br><i>UNIVERSITY MEDICAL SCHOOL</i>  |
| <b>HOSPITAL DISPOSAL</b>   |  |  |   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| C-623 69 10662  |                         |  |                                   | BALTIMORE CITY HEALTH DEPARTMENT   |                             | REG. NO. 69 10662   |  |
|---|-------------------------|--|-----------------------------------|--|-----------------------------|---|--|
| BIRTH NO.   |                         |  |                                   | 1. NAME OF DECEASED<br>(Type or Print) <b>CORCODILOS, Leonides</b>   |                             | 2. DATE AND HOUR OF DEATH<br><b>10/11/69 9:20 A.</b>  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                         |  |                                   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>202</b> |                             |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>33</b><br><b>The Johns Hopkins Hospital</b>  |                         |  |                                   | C. CITY OR TOWN<br><b>Baltimore</b>  |                             | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>     |  |
|   |                         |  |                                   | E. STREET AND NUMBER<br><b>117 S. Broadway</b>   |                             |   |  |
| 5. SEX<br><b>Male</b>   | 6. RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1/1/95</b> | 9. AGE (In years last birthday)<br><b>74</b>   | If Under 1 Yr. Months: Days | If Under 24 Hrs. Hours: Min.  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                         |  |                                   | 10B. KIND OF BUSINESS OR INDUSTRY  |                             | 11. BIRTHPLACE (State or foreign country)   |  |
| 12. CITIZEN OF WHAT COUNTRY?  |                         |  |                                   |  |                             |   |  |
| 13. FATHER'S NAME   |                         |  |                                   | 14. MOTHER'S MAIDEN NAME   |                             |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |                         |  |                                   | 16. SOCIAL SECURITY NO.  |                             | 17. INFORMANT ADDRESS   |  |
| 18. <b>44171</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b><br><b>CARDIORESPIRATORY ARREST</b><br><b>MYOCARDIAL INFARCTION</b><br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>PNEUMOCOCCAL PNEUMONIA</b><br><b>PNEUMOCOCCAL SEPTICEMIA</b><br><b>ASHD, LHF</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>COPD</b><br><b>ARTIC ANEURYSM</b><br>(C) <b>AI</b><br><b>CARDIOVASCULAR</b><br><b>OVERWHELMING LIVER FAILURE</b><br><b>superimposed on cardiorespiratory</b><br><b>consumption</b><br><b>conjugate</b><br><b>pendig permiss</b> |                         |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 TB</b>  |                             |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                         |  |                                   |  |                             |   |  |
| 19A. DATE OF OPERATION<br><b>21</b>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                   | 20A. AUTOPSY? (Yes or No)<br><b>YES</b>  |                             | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>PENDING PERMISSION</b> |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                                   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                             |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                         | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                                   | 21F. HOW DID INJURY OCCUR?   |                             |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10/9</b> <b>1969</b> to <b>10/11</b> <b>1969</b> , that (I) (we) last saw the deceased alive on <b>10/11</b> <b>1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                         |  |                                   |  |                             |   |  |
| 23A. SIGNATURE<br><b>Ralph DeFronzo, M.D.</b>   |                         |  |                                   | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>        |                             | 23B. DATE SIGNED<br><b>10/11/69</b>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Ralph DeFronzo, M.D.</b>   |                         |  |                                   | 23D. ADDRESS<br><b>The Johns Hopkins Hospital</b>  |                             |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |                         | 24B. DATE<br><b>10-21-69</b>   |                                   | 24C. NAME OF CEMETERY or CREMATOR<br><b>ANATOMY BOARD OF MARYLAND</b>  |                             | (State)   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 30 1969</b>   |                         | 25B. NAME OF REGISTRAR<br><b>John E. [illegible]</b>   |                                   | 25C. FUNERAL DIRECTOR<br><b>UNIVERSITY MEDICAL SCHOOL</b>  |                             | ADDRESS<br><b>MORTUARY SERVICE - BCHD</b>   |  |

ONE HUNDRED AND SEVENTY FIVE

THIRTY TWO

THIRTY TWO

THIRTY TWO

THIRTY TWO

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THIRTY TWO

THIRTY TWO

THIRTY TWO

THIRTY TWO

THIRTY TWO

Ralph D. F. King, M.D.

10/1/61

1  
S-120 69 10663 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 69 10663

|   |  |  |  |  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|
| BIRTH NO.   |  | 1. NAME OF DECEASED<br>(Type or Print) |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> |  | Month  |  | Day  |  | Year   |  | Hour   |  |
|   |  | Carl Speck                             |  |  |  | 9  |  | 27   |  | 69   |  | 3:20 p.m.                                    |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |  |  |  | 3. DATE PRONOUNCED DEAD  |  | Month  |  | Day  |  | Year   |  | Hour   |  |
| 00 514 E. Pratt St.   |  |  |  | 9  |  | 27   |  | 69   |  | 3:20 p.m.  |  |  |  |
| 6. SEX  |  |  |  | 7. RACE  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  | C. CITY OR TOWN  |  | D. INSIDE CITY LIMITS?                                   |  |  |  |
| male  |  | white                                  |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                               |  |  |  | Baltimore  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 9. DATE OF BIRTH  |  | 10. AGE (In years lost birthday)       |  | 11. BIRTHPLACE (State or foreign country)  |  | 12. CITIZEN OF WHAT COUNTRY?   |  | E. STREET AND NUMBER   |  |  |  |  |  |
|   |  | 59                                     |  |  |  |  |  | 514 E. Pratt St.   |  |  |  |  |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  |  |  | 14B. KIND OF BUSINESS OR INDUSTRY  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)   |  |  |  | 17. SOCIAL SECURITY NO.  |  |  |  | 18. INFORMANT ADDRESS  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 19. 5718 I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  |  |  |  | CAUSE OF DEATH   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|   |  |  |  | (A) IMMEDIATE CAUSE Fatty alteration of liver<br>DUE TO, OR AS A CONSEQUENCE OF:                 |  |  |  |  |  |  |  |  |  |
|   |  |  |  | (B) DUE TO, OR AS A CONSEQUENCE OF:  |  |  |  |  |  |  |  |  |  |
|   |  |  |  | (C) DUE TO, OR AS A CONSEQUENCE OF:  |  |  |  |  |  |  |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 20A. DATE OF OPERATION  |  |  |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  |  |  |  | 21. AUTOPSY? (Yes or No)                     |  |
|   |  |  |  |  |  |  |  |  |  |  |  | yes  |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |  |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)         |  |  |  | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22D. TIME OF INJURY (APPROX.)   |  |  |  | 22E. INJURY OCCURRED   |  |  |  | 22F. HOW DID INJURY OCCUR?   |  |  |  |  |  |
|   |  |  |  | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                |  |  |  |  |  |  |  |  |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE  |  |  |  | EXAMINER'S NAME (Type)   |  |  |  | Deputy Chief Medical Examiner  |  |  |  | DATE SIGNED                                  |  |
| Werner U. Spitz, M.D.   |  |  |  |  |  |  |  |  |  |  |  | 9/28/69                                      |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |  |  |  | 24B. DATE  |  |  |  | 24C. NAME OF CEMETERY  |  |  |  | 24D. NAME OF FUNERAL HOME                    |  |
| Cremated  |  |  |  | 10-15-69   |  |  |  |  |  |  |  |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.   |  |  |  | 25B. NAME OF REGISTRAR   |  |  |  | 25C. FUNERAL DIRECTOR  |  |  |  | ADDRESS                                      |  |
| OCT 30 1969   |  |  |  | Robert E. Fabel, Jr.   |  |  |  |  |  |  |  |  |  |

ANATOMY BOARD OF MARYLAND  
UNIVERSITY MEDICAL SCHOOL  
HOSPITAL DISPOSAL



100-10000

100-10000

3718

100-10000

100-10000

100-10000

100-10000



Released by Medical Examiner 10/27/68  
FUNERAL DIRECTOR: IMPORTANT  
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |          |  |  |  |                   |  |  |  |  |  |
|--|--|----------|--|--|--|-------------------|--|--|--|--|--|
| M-450  |  | 69 10664 |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | REG. NO. 69 10664 |  |  |  |  |  |
| BIRTH NO.  |  |          |  | 1. NAME OF DECEASED<br>(Type or Print) AGNES A. MULLANEY   |  |                   |  | 2. DATE AND HOUR OF DEATH<br>12/27/68 9 45 P.M.  |  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |          |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE MD B. COUNTY   |  |                   |  | 5. CITY OR TOWN  |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>Union Memorial Hospital  |  |          |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>44   |  |                   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 5. SEX<br>F  |  |          |  | 6. RACE<br>Cau.  |  |                   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife   |  |          |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  |                   |  | 8. DATE OF BIRTH<br>6/28/11  |  |  |  |
| 13. FATHER'S NAME<br>Joseph H. Butts   |  |          |  | 14. MOTHER'S MAIDEN NAME<br>Mary Agnes Adesberger  |  |                   |  | 9. AGE (In years lost birthday)<br>59  |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No   |  |          |  | 16. SOCIAL SECURITY NO.<br>-   |  |                   |  | 17. INFORMANT<br>John L. Mullaney Jr. - 4631 Asbury Ave. - 21206   |  |  |  |
| 18. 431.9 I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  |          |  | CAUSE OF DEATH<br>Brain Stem Cerebral Hemorrhage<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF: |  |                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| MEDICAL CERTIFICATION<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br>II<br>Severe pulmonary edema & congestion H.  |  |          |  | 19A. DATE OF OPERATION<br>2  |  |                   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)  |  |          |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  |                   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |  |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |  |          |  | 21E. INJURY OCCURRED<br>White AI <input type="checkbox"/> Not White AI Work <input type="checkbox"/>   |  |                   |  | 21F. HOW DID INJURY OCCUR  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 12/27/68 to 12/28/68 that (I) (we) last saw the deceased alive on 12/27/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |  |          |  | 23A. SIGNATURE<br>G. H. V. Ribeiro MD  |  |                   |  | 23B. DATE SIGNED<br>12/27/68   |  |  |  |
| 23C. PHYSICIAN'S NAME (Type)<br>G. H. V. Ribeiro MD  |  |          |  | 23D. ADDRESS<br>Union Memorial Hosp.   |  |                   |  | 23E. FUNERAL DIRECTOR<br>John C. Miller Inc - 6415 Belair Rd. - 21206  |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial   |  |          |  | 24B. DATE<br>10-29-69  |  |                   |  | 24C. NAME of CEMETERY or CREMATORY<br>Baltimore National Cemetery  |  |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>OCT 30 1969   |  |          |  | 25B. NAME OF REGISTRAR<br>John C. Miller   |  |                   |  | 25C. FUNERAL DIRECTOR<br>John C. Miller Inc - 6415 Belair Rd. - 21206  |  |  |  |

Handwritten text, likely bleed-through from the reverse side of the page, including the word "Xenon".

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |  |   |  |  |
|---|--|--|---|--|--|
| M-300   |  | BALTIMORE CITY HEALTH DEPARTMENT   |   | REG. NO. 69 10665  |  |
| BIRTH NO.   |  | 69 10665   |   | CERTIFICATE OF DEATH   |  |
| 1. NAME OF DECEASED<br>(Type in Print)<br>MRS. JULIA MUTH   |  |  | 2. DATE AND HOUR OF DEATH<br>OCTOBER 27, 1969 5 50 P. M.  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>Bon Secours Hospital  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE B. COUNTY<br>Maryland Baltimore 21229 |  |  |
| 5. SEX<br>F   |  |  | 6. RACE<br>W  |  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  | 8. DATE OF BIRTH<br>9/21/91 (13)  |  |  |
| 9. AGE (In years last birthday)<br>78   |  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 11. BIRTHPLACE (State or foreign country)<br>Maryland   |  |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  |
| 13. FATHER'S NAME<br>CHARLES ECKERT   |  |  | 14. MOTHER'S MAIDEN NAME<br>EMMA  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No  |  |  | 16. SOCIAL SECURITY NO.<br>216-24-662   |  |  |
| 17. INFORMANT<br>Mr. Henry Frey 202 Westshire Rd.   |  |  | ADDRESS<br>North Bend, Balto. Md.   |  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>C.V.A.  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>Myocardial Infarction<br>A S C Y D.   |  |  |   |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |  |   |  |  |
| 19A. DATE OF OPERATION  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No)<br>Refused                                     |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                             |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME OF INJURY (APPROX.)   |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (1) (this hospital) attended the deceased from 10-21-69 to 10-27-69 that (1) (we) last saw the deceased alive on 10-27-69 and that (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. |  |  |   |  |  |
| 23A. SIGNATURE<br>DR. Qureshi   |  |  | 23B. DATE SIGNED<br>10.27.69  |  |  |
| 23C. PHYSICIAN'S NAME (Type)<br>DR. QURESHI   |  |  | 23D. ADDRESS<br>Bon Secours Hospital Baltimore  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |  | 24B. DATE  |   | 24C. NAME OF CEMETERY OR CREMATORY                                       |  |
| Burial  |  | Oct. 31, 1969  |   | Baltimore, Cemetery  |  |
| 24D. LOCATION   |  | 24E. LOCATION  |   | 24F. LOCATION  |  |
| Balto. Md.  |  | Balto. Md.   |   | Balto. Md.   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>OCT 30 1969  |  | 25B. NAME OF REGISTRAR<br>Robert E. Taylor   |   | 25C. FUNERAL DIRECTOR<br>G. Truman Schwab 5151 Balto. National Pike      |  |

Aug 23

1888

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

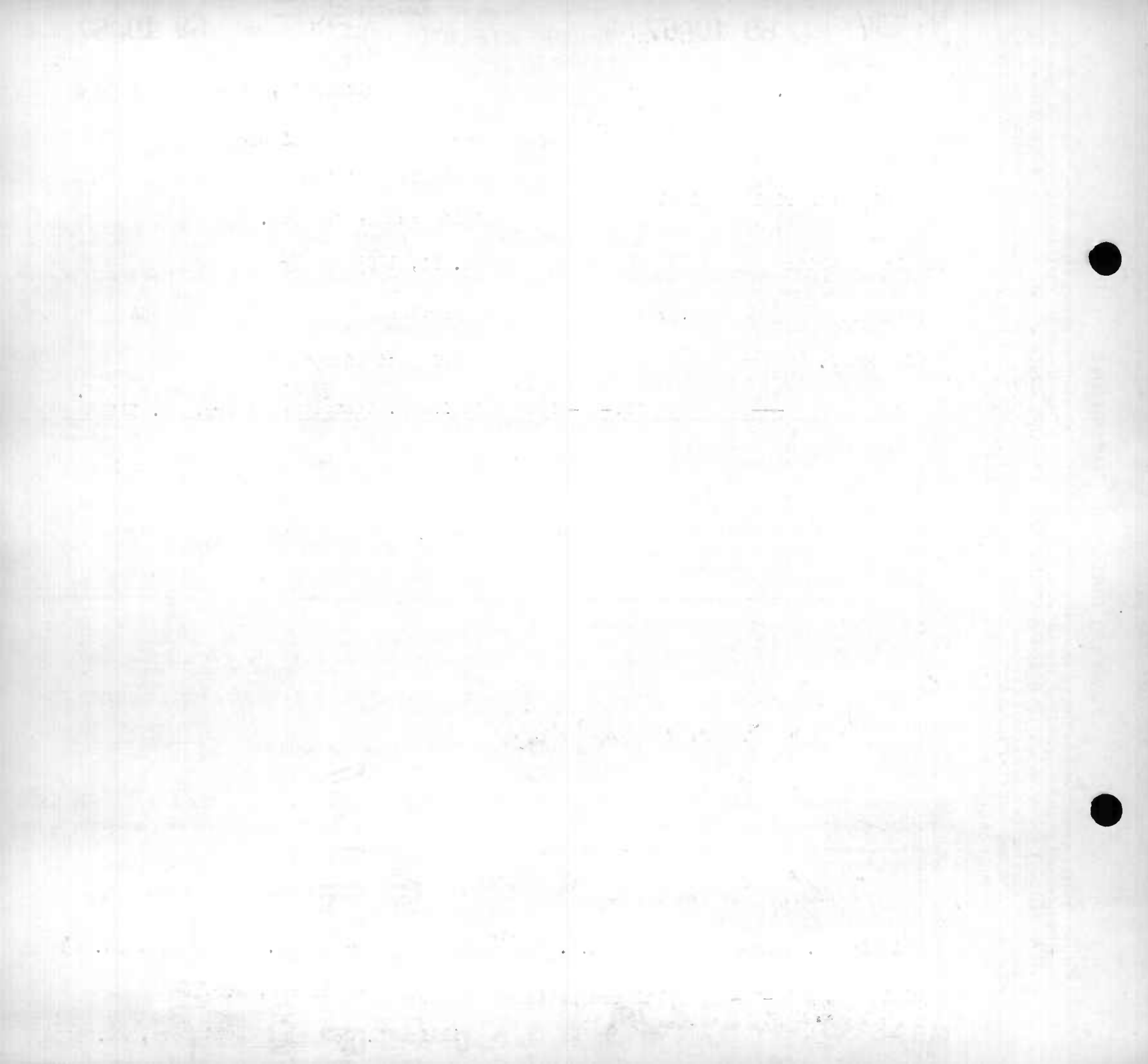
|   |                             |   |   |
|---|-----------------------------|---|---|
| <p><b>5-460</b></p> <p><b>69 10666 CERTIFICATE OF DEATH</b></p>   |                             | <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>REG. NO. <b>69 10666</b></p>   |   |
| <p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) <b>JAMES SHEELER</b></p>  |                             | <p>2. DATE AND HOUR OF DEATH <b>10/25/69 9:20 pm</b></p>  |   |
| <p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><b>33 THE JOHNS HOPKINS HOSPITAL</b></p>  |                             | <p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <b>BALTIMORE COUNTY MARYLAND</b> <b>5300</b></p> <p>C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>E. STREET AND NUMBER <b>202 McCORMICK AVENUE</b> <b>21206</b></p> |   |
| <p>5. SEX <b>MALE</b></p>   | <p>6. RACE <b>WHITE</b></p> | <p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></p> <p>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>  | <p>8. DATE OF BIRTH <b>4-18-08</b></p> <p>9. AGE (In years last birthday) <b>61</b></p> <p>If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.</p> |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p><b>Selfemployed</b></p>   |                             | <p>10B. KIND OF BUSINESS OR INDUSTRY <b>Hat Business</b></p>  |   |
| <p>11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b></p>  |                             | <p>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b></p>   |   |
| <p>13. FATHER'S NAME <b>ALEXANDER SHEELER</b></p>   |                             | <p>14. MOTHER'S MAIDEN NAME <b>EDITH Lowry</b></p>  |   |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p><b>No</b></p>  |                             | <p>16. SOCIAL SECURITY NO. <b>216-32-7654</b></p>   |   |
| <p>17. INFORMANT <b>Mrs Hanie Sheeler</b></p>   |                             | <p>ADDRESS <b>202 McCormick Avenue</b></p>  |   |
| <p>18. <b>4 12 4 I</b></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>    |                             | <p>CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiorespiratory arrest</b></p> <p>(B) <b>Severe cardiac failure</b> DUE TO, OR AS A CONSEQUENCE OF: <b>2-3 yrs</b></p> <p>(C) <b>Atherosclerotic Cardiovascular disease</b> <b>15 yrs</b></p>   |   |
| <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b></p>  |                             |   |   |
| <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>   |                             |   |   |
| <p>19A. DATE OF OPERATION <b>2</b></p>  |                             | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>   |   |
| <p>20A. AUTOPSY? (Yes or No) <b>YES</b></p>   |                             | <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>   |   |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>  |                             | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>   |   |
| <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>   |                             |   |   |
| <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>  |                             | <p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>  |   |
| <p>21F. HOW DID INJURY OCCUR?</p>   |                             |   |   |
| <p>22. I certify that (I) (this hospital) attended the deceased from <b>6 p.m. 10/25</b> 19 <b>69</b> to <b>9:20 pm 10/25</b> 19 <b>69</b>, that (I) (we) last saw the deceased alive on <b>10/25</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.</p> |                             |   |   |
| <p>23A. SIGNATURE <b>William L. Horvath</b></p>   |                             | <p>23B. DATE SIGNED <b>10/25/69</b></p>   |   |
| <p>23C. PHYSICIAN'S NAME (Type) <b>WILLIAM L. HORVATH</b></p>   |                             | <p>23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b></p>   |   |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b></p>   |                             | <p>24B. DATE <b>10-28-69</b></p>  |   |
| <p>24C. NAME OF CEMETERY or CREMATORY <b>Gardens of Faith</b></p>   |                             | <p>24D. LOCATION (City, town, or county) (State) <b>Fullerton Balto. Md.</b></p>  |   |
| <p>25A. DATE REC'D BY HEALTH DEPT. <b>OCT 30 1969</b></p>   |                             | <p>25B. NAME OF REGISTRAR <b>Charles E. [unclear]</b></p>   |   |
| <p>25C. FUNERAL DIRECTOR <b>Lassahn Funeral Home</b></p>  |                             | <p>ADDRESS</p>  |   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |   |  |  |
|--|---|--|--|
| <div style="display: flex; justify-content: space-between;"> <span>B-534</span> <span>69 10667</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <div style="display: flex; justify-content: space-between;"> <span>CERTIFICATE OF DEATH</span> <span>REG. NO. 69 10667</span> </div>  |   |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>AGNES A. BANDEL</b>  |   | 2. DATE AND HOUR OF DEATH<br><b>October 27, 1969</b>   <b>2:30 A</b> M.  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>44 Union Memorial Hospital</b>   |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b><br>C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>E. STREET AND NUMBER <b>8315 Loch Raven Blvd.</b> |  |
| 5. SEX <b>Female</b>   | 6. RACE <b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <b>Feb. 12, 1893</b>                                    |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>   |   | 10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>  | 9. AGE (In years lost birthday) <b>76</b>                                |
| 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |
| 13. FATHER'S NAME <b>Gilbert J. Hughes</b>   |   | 14. MOTHER'S MAIDEN NAME <b>Bridgett Fitzpatrick</b>   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO. <b>217-69-6246</b>   |  |
| 17. INFORMANT <b>William M. Bandel</b>   |   | ADDRESS <b>8315 Lock Raven Blvd. Baltimore, Md. 21204</b>  |  |
| 18. <b>410.9 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>Coronary Thrombosis</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b><br><b>(B) Arterio Sclerosis of Coronary Artery</b><br><b>(C) ...</b> |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hrs</b><br><b>3 yrs</b>   |  |
| MEDICAL CERTIFICATION<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>II</b>   |   |  |  |
| 19A. DATE OF OPERATION <b>0</b>  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20A. AUTOPSY? (Yes or No)  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?     |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>11/14/68</b> to <b>10/27</b> 19 <b>68</b> , that (I) <del>last</del> last saw the deceased alive on <b>10/19/69</b> 19 <b>69</b> and that in (my) <del>last</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>last</del> <del>view</del> (did not) view the body after death.  |   |  |  |
| 23A. SIGNATURE <b>William M. Conway</b>  |   | 23B. DATE SIGNED <b>10/28/69</b>   |  |
| 23C. PHYSICIAN'S NAME (Type) <b>William M. Conway</b>  |   | 23D. ADDRESS <b>M.D. 8358 Loch Raven Blvd. Baltimore, Md. 04</b>   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>   | 24B. DATE <b>10-29-69</b>   | 24C. NAME of CEMETERY or CREMATORY <b>Baltimore National Cemetery</b>  | 24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b> |
| 25A. DATE REC'D BY HEALTH DEPT. <b>OCT 30 1969</b>   |   | 25B. NAME of REGISTRAR <b>William M. Johnson</b>   |  |
| 25C. FUNERAL DIRECTOR <b>William M. Johnson</b>  |   | ADDRESS <b>8521 Loch Raven Blvd Baltimore, Md. 21204</b>   |  |

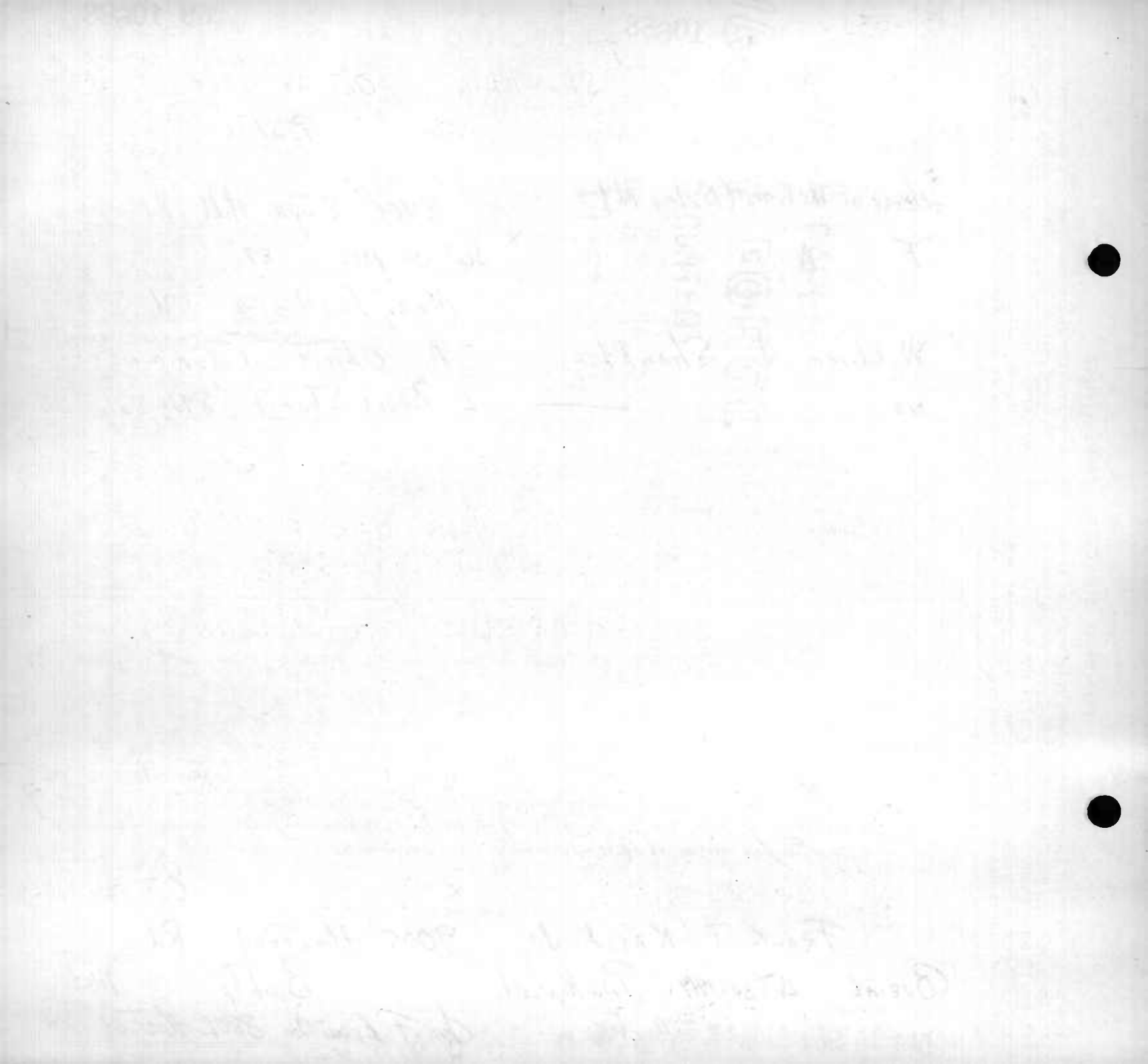




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                     |   |  |  |                            |   |  |
|--|---------------------|---|--|--|----------------------------|---|--|
| 3-524  |                     | 69 10668  |  | BALTIMORE CITY HEALTH DEPARTMENT   |                            | X REG. NO. 69 10668   |  |
| BIRTH NO.  |                     | 1. NAME OF DECEASED<br>(Type or Print) <i>Mabel C. Shanklin</i>   |  | 2. DATE AND HOUR OF DEATH<br><i>Oct 28 1969 3:30 A.M.</i>  |                            |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                     |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <i>MD</i> B. COUNTY <i>BALTO</i> <i>5300</i> |                            |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><i>House of the Poor (Belair Rd)</i>  |                     |   |  | C. CITY OR TOWN<br><i>CARNEY</i>   |                            | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
|  |                     |   |  | E. STREET AND NUMBER<br><i>8906 SATYR HILL Rd</i>  |                            |   |  |
| 5. SEX<br><i>F</i>   | 6. RACE<br><i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>Sept 30, 1882</i> | 9. AGE (In years last birthday)<br><i>87</i>   | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                     | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><i>MARYLAND</i>   |                            | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  |
| 13. FATHER'S NAME<br><i>WILLIAM J. SHANKLIN</i>  |                     |   |  | 14. MOTHER'S MAIDEN NAME<br><i>A. OLIVIA CROMMELL</i>  |                            |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>NO</i>  |                     | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS<br><i>E. BRUCE STUART 8920 SATYR HILL Rd</i>   |                            |   |  |
| 18. <i>492 X I</i> CAUSE OF DEATH  |                     |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>2-3 Wks</i>   |                            |   |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)   |                     |   |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><i>Pneumonia</i>  |                            |   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                     |   |  | (B) DUE TO, OR AS A CONSEQUENCE OF:<br><i>Emphysema Basilar atelectasis</i><br><i>Arteriosclerotic Vascular Disease</i>                        |                            |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                     |   |  | <i>Cerebrovascular Ischemia &amp; Senility</i>   |                            |   |  |
| 19A. DATE OF OPERATION<br><i>0</i>   |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)  |                            | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                            |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?   |                            |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Jan 18 1969</i> to <i>Oct 28 1969</i> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                     |   |  |  |                            |   |  |
| 23A. SIGNATURE<br><i>Frank T. Kasik Jr.</i>  |                     |   |  | 23B. DATE SIGNED<br><i>Oct 29 1969</i>   |                            |   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><i>FRANK T. KASIK JR.</i>  |                     |   |  | 23D. ADDRESS<br><i>9005 HARTFORD Rd</i>  |                            |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>BURIAL</i>  |                     | 24B. DATE<br><i>AT 30-1969</i>  |  | 24C. NAME OF CEMETERY or CREMATORY<br><i>PARKWOOD</i>  |                            | 24D. LOCATION (City, town, or county) (State)<br><i>BALTO MD</i>                              |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>OCT 30 1969</i>  |                     | 25B. NAME OF REGISTRAR<br><i>Robert E. Taylor</i>   |  | 25C. FUNERAL DIRECTOR<br><i>Chas. F. Evans</i>   |                            | ADDRESS<br><i>8802 HARTFORD Rd</i>  |  |



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |   |  |   | REG. NO. <b>69 10669</b>   |
|--|---|--|---|--|
| <b>17-426</b>  |   | <b>69 10669</b>  |   | <b>CERTIFICATE OF DEATH</b>  |
| BIRTH NO.  |   | 1. NAME OF DECEASED<br>(Type or Print) <b>JAMES A MULKERN JR.</b>  |   |  |
| 2. DATE AND HOUR OF DEATH<br><b>10/28/69</b>   |   | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><b>Union Memorial Hospital</b>   |   |  |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>1203</b>   |   | 5. SEX <b>M</b> 6. RACE <b>W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  |
| C. CITY OR TOWN <b>BALTIMORE</b>   |   | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |  |
| E. STREET AND NUMBER <b>445 ILCHESTER AVE.</b>   |   | 8. DATE OF BIRTH <b>May 14-07-62</b> 9. AGE (In years last birthday) <b>7</b>  |   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>   |   | 10B. KIND OF BUSINESS OR INDUSTRY <b>Key-Hing(sy)</b>  |   | 11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>                |
| 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |   | 13. FATHER'S NAME <b>JAMES MULKERN</b>   |   |  |
| 14. MOTHER'S MAIDEN NAME <b>MRS FERN DUCAN</b>   |   | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>   |   |  |
| 16. SOCIAL SECURITY NO. <b>214-18-0583</b>   |   | 17. INFORMANT <b>MRS JAMES A. MULKERN</b> ADDRESS <b>445 ILCHESTER AVE.</b>  |   |  |
| 18. CAUSE OF DEATH<br><b>4/12.4 I</b>  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)   |   | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardio-respiratory arrest</b>   |   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |   | (B) <b>2° myocardial failure due to ASCVD</b> 14<br>(C) <b>any Chronic obstructive lung disease</b> 14   |   |  |
| <b>II</b>  |   |  |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |   |  |   |  |
| 19A. DATE OF OPERATION <b>0</b>  |   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No) <b>NO</b>                                      |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.)  |   | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |   | 21F. HOW DID INJURY OCCUR?   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10/24</b> 19 <b>69</b> to <b>10/28</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>10/28/69</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |   |  |   |  |
| 23A. SIGNATURE <b>Anne L. Leddy M.D.</b>   |   |  |   | 23B. DATE SIGNED <b>10/28/69</b>   |
| 23C. PHYSICIAN'S NAME (Type) <b>ANNE L. LEDDY M.D.</b>   |   | 23D. ADDRESS <b>Union Memorial Hospital</b>  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>   | 24B. DATE <b>10/31/69</b>                   | 24C. NAME OF CEMETERY or CREMATORY <b>OAK LAWN CEM.</b>  | 24D. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b> |  |
| 25A. DATE REC'D BY HEALTH DEPT. <b>OCT 30 1969</b>   | 25B. NAME OF REGISTRAR <b>John E. Kelly</b> | 25C. FUNERAL DIRECTOR <b>J.G. CONNELLY SONS</b>  |   | ADDRESS <b>300 MACE</b>  |

Union-Insurance Topical

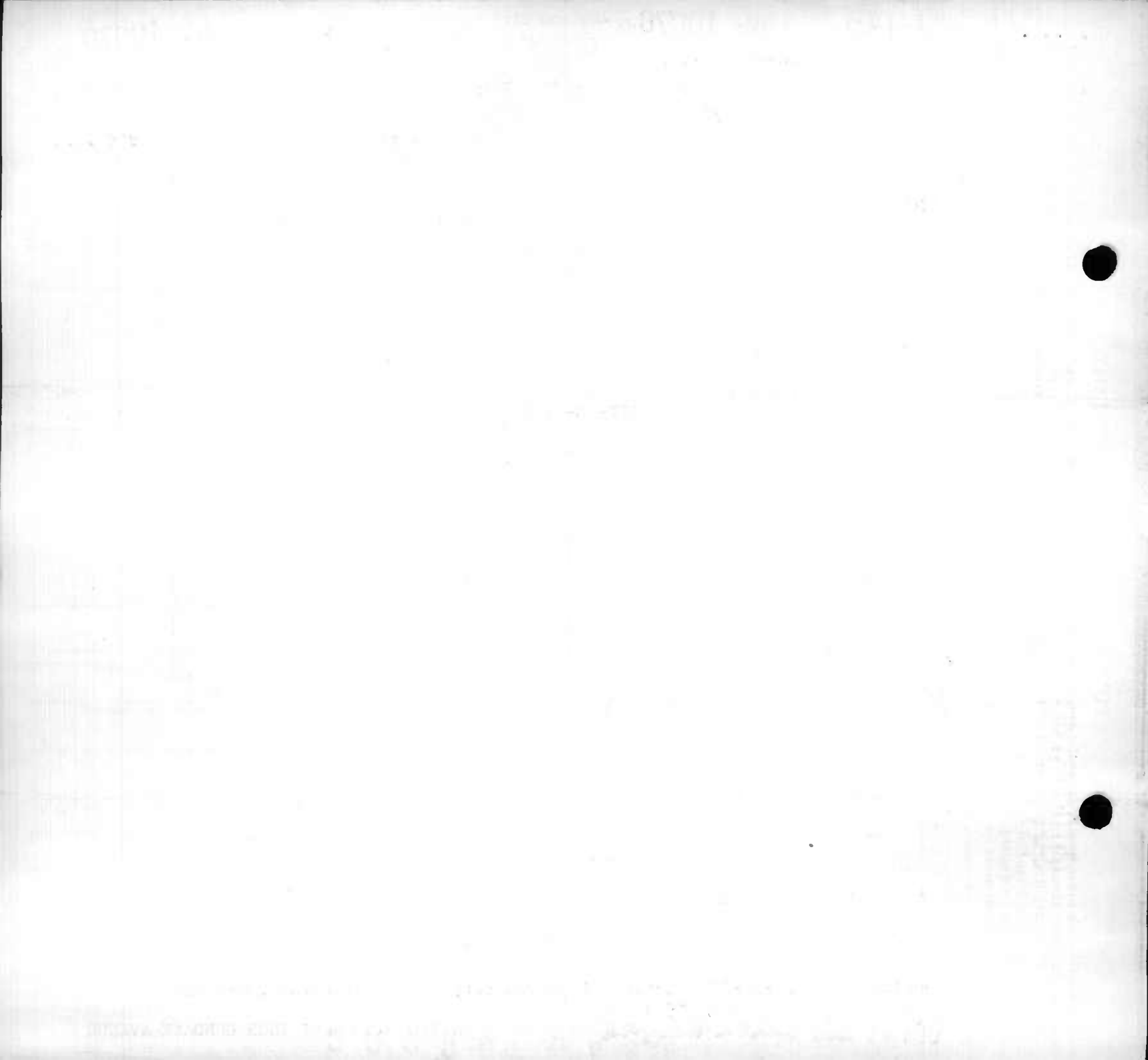
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Union-Insurance Topical  
BRIAL 1914  
TO COMMISSIONERS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |              |   |  |  |  |   |  |   |  |
|--|--------------|---|--|--|--|---|--|---|--|
| W-123  |              | 69 10670  |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | X   |  | REG. NO. 69 10670   |  |
| BIRTH NO.  |              | Rachel Webster  |  |  |  |   |  |   |  |
| 1. NAME OF DECEASED<br>(Type or Print)   |              | RACHEL WEBSTER  |  |  |  | 2. DATE AND HOUR OF DEATH<br>10-27-69 4:40 A.M.   |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |              |   |  |  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence below admission)  |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>South Balto. Gen. Hosp.<br>43  |              |   |  |  |  | A. STATE<br>BALTO.  |  | B. COUNTY<br>MD.  |  |
|  |              |   |  |  |  | C. CITY OR TOWN<br>BALTO.   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| E. STREET AND NUMBER<br>6901 German Hill Rd  |              |   |  |  |  |   |  |   |  |
| 5. SEX<br>♀  | 6. RACE<br>W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>2-18-08  |  | 9. AGE (in years last birthday)<br>61   |  | 11. BIRTHPLACE (State or foreign country)<br>Maryland   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Inspector   |              | 10B. KIND OF BUSINESS OR INDUSTRY<br>Beth. Steel  |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                   |  |   |  |   |  |
| 13. FATHER'S NAME<br>Daniel Lee  |              |   |  |  |  | 14. MOTHER'S MAIDEN NAME<br>Maggie  |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces?<br>(Was, no or at unknown) If yes, give war or dates of service<br>No   |              | 16. SOCIAL SECURITY NO.<br>577-10-3912  |  | 17. INFORMANT<br>Louis 6901 German Hill Rd. Balto. Md. 22                |  |   |  |   |  |
| 18. 410.7 I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>Massive Myocardial Infarction   |              |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) Arteriosclerotic Cardio<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) Vascular Disease                             |              |   |  |  |  |   |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |              |   |  |  |  |   |  |   |  |
| 19A. DATE OF OPERATION<br>None   |              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br>no  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)  |              | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |   |  |   |  |
| 21D. TIME OF INJURY (APPROX.)  |              | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?   |  |   |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from 10-23 19 69 to 10-27 19 69 that (I) (we) last saw the deceased alive on 10-27 19 69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |              |   |  |  |  |   |  |   |  |
| 23A. SIGNATURE<br>Lilia C. Baldonado, M.D.   |              |   |  |  |  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |  | 23B. DATE SIGNED<br>10-27-69  |  |
| 23C. PHYSICIAN'S NAME (Type)<br>LILIA C. BALDONADO M.D.  |              |   |  |  |  | 23D. ADDRESS<br>South Balto. Gen. Hosp.   |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial   |              | 24B. DATE<br>10-30-69   |  | 24C. NAME OF CEMETERY or CREMATORY<br>Meadow Ridge Cemetery              |  | 24D. LOCATION<br>Baltimore, Maryland  |  | 24E. LOCATION<br>City, town, or county   State  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>OCT 30 1969   |              | 25B. NAME OF REGISTRAR<br>Robert E. Taylor, Jr.   |  | 25C. FUNERAL DIRECTOR<br>WALTER DABROWSKI                                |  | 25D. ADDRESS<br>1005 DUNDALK AVENUE   |  |   |  |



K-510

69 10671 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 10671

BIRTH NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>FRANCIS WILLIAM KNAUFF</b>  |  |   |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> M.               |  |   |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>002010 N. Charles St. Apt. 1</b>  |  |   |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>Oct. 27 1969 1:25 p.m.</b>   |  |   |  |
| 6. SEX<br><b>Male</b>   |  |   |  | 7. RACE<br><b>White</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. DATE OF BIRTH<br><b>6/18/23</b>  |  |   |  | 10. AGE (In years last birthday)<br><b>46</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore</b>   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  | 13. FATHER'S NAME<br><b>James Knauff</b>  |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Repairman</b>  |  |
| 15. MOTHER'S MAIDEN NAME<br><b>Anna Corbett</b>   |  |   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>N YES WW II</b> |  | 17. SOCIAL SECURITY NO.<br><b>216-18-0113</b>   |  |
| 18. INFORMANT: <b>Mother</b>  |  |   |  | 19. ADDRESS<br><b>Anna C. Knauff, 4113 Woodlea Ave. 21206</b>   |  |   |  |
| 20. DATE OF OPERATION<br><b>2</b>   |  |   |  | 21. AUTOPSY? (Yes or No)<br><b>YES</b>  |  |   |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.   |  |   |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Unknown</b>                    |  |   |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br><b>Unknown</b>  |  |   |  | 22D. TIME OF INJURY (Approx.)<br>Month Day Year Hour<br><b>? ? ? ?</b>  |  |   |  |
| 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> ? NOT WHILE AT WORK <input type="checkbox"/><br><b>Unknown</b>   |  |   |  | 22F. HOW DID INJURY OCCUR?<br><b>Unknown</b>  |  |   |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE: <b>Werner U. Spitz, M.D.</b> M.D.<br>EXAMINER'S NAME (Type): <b>Werner U. Spitz, M.D.</b><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED: <b>10/28/69</b> |  |   |  |   |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 24B. DATE<br><b>10/30/69</b>                          |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Baltimore National Cem.</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 30 1969</b>   |  | 25B. NAME OF REGISTRAR<br><b>John E. Fisher, M.D.</b> |  | 25C. FUNERAL DIRECTOR ADDRESS<br><b>Stewart &amp; Mowen Co. 108 W. North Ave. City 1</b>                                      |  |   |  |

10-10-51

10-10-51

WALTER BROWN

NEW YORK

10-10-51



1

L-535 69 10672 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 69 10672

BIRTH NO.

|   |  |   |  |
|---|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>WILLIAM LANDMON</b>   |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> Hour M. |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>314 N. Poppleton Street</b> |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>September 25, 1969 12:15 P.M.</b>                          |  |
| 6. SEX<br><b>Male</b>   |  | 7. RACE<br><b>Negro</b>   |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | C. CITY OR TOWN<br><b>Baltimore</b>   |  |
| 9. DATE OF BIRTH<br>10. AGE (In years last birthday)<br><b>70</b>   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                   |  |
| 11. BIRTHPLACE (State or foreign country)   |  | E. STREET AND NUMBER<br><b>314 N. Poppleton Street</b>  |  |
| 12. CITIZEN OF WHAT COUNTRY?  |  | 13. FATHER'S NAME   |  |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 15. MOTHER'S MAIDEN NAME  |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)   |  | 17. SOCIAL SECURITY NO.   |  |
| 18. INFORMANT   |  | ADDRESS   |  |

19. **E968X** CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) IMMEDIATE CAUSE **Subdural hematoma**  
DUE TO, OR AS A CONSEQUENCE OF:

(B) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF:

(C) \_\_\_\_\_

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION  
**2**

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)  
**Yes**

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  
**alley**

22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  
**Rear of 300 block N. Fremont Ave.**

22D. TIME OF INJURY (APPROX.)  
**9-24-69 5:00 P.m.**

22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?  
**Assaulted during attempted robbery**

23. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE **Charles S. Springate, M.D.**

EXAMINER'S NAME (Type) **Charles S. Springate, M.D.**

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED **September 25, 1969**

24A. BURIAL CREMATION, REMOVAL (Specify)  
**CREMATED**

24B. DATE  
**10-15-69**

24C. NAME OF CEMETERY OR CREMATORY  
**ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL**

24D. ADDRESS  
**HOSPITAL DISPOSAL**

25A. DATE REC'D BY HEALTH DEPT.  
**OCT 30 1969**

25B. NAME OF REGISTRAR  
**Robert E. Fisher, M.D.**

25C. FUNERAL DIRECTOR

VS 151-REV. 1/1/68

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                      |  |   |
|--|----------------------|--|---|
| BALTIMORE CITY HEALTH DEPARTMENT   |                      | REG. NO. <b>69 10673</b>   |   |
| BIRTH NO. <b>K-640</b>   |                      | 69 10673 <b>CERTIFICATE OF DEATH</b>   |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>BELA KAROLYI</b>   |                      | 2. DATE AND HOUR OF DEATH<br><b>Oct. 13, 1969</b> <b>1:30 P.M.</b>   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><b>CERTIFICATE AMENDED</b><br>HOSPITAL OR INSTITUTION <b>40</b><br><b>1237 TEN OAKS RD.</b><br><b>St. Agnes Hospital - DOA</b>   |                      | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b><br>C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/><br>E. STREET AND NUMBER <b>1237 TEN OAKS RD.</b> |   |
| 5. SEX <b>MALE</b>   | 6. RACE <b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <b>JUNE 2/96</b> 9. AGE (In years last birthday) <b>73 YRS</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>  |                      | 10B. KIND OF BUSINESS OR INDUSTRY <b>GENERAL TIRE Co</b>   | 11. BIRTHPLACE (State or foreign country) <b>AUSTRIA</b>                        |
| 13. FATHER'S NAME  |                      | 14. MOTHER'S MAIDEN NAME <b>U.S.A.</b>   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |                      | 16. SOCIAL SECURITY NO.  |   |
| 17. INFORMANT <b>MRS. INGE K. McLAUGHLIN</b>   |                      | ADDRESS <b>1237 TEN OAKS AVE.</b>  |   |
| 18. <b>410.9 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>ACUTE MYOCARDIAL INFARCTION</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                      | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>Coronary atherosclerosis?</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____  |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br>19A. DATE OF OPERATION <b>19/30/69</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Benign Prostatic Hypertrophy</b> 20A. AUTOPSY? (Yes or No) <b>None</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                   |                      |  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |   |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                      | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |   |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                      | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>7/6/69</b> to <b>10/13/69</b> , that (I) (we) last saw the deceased alive on <b>10/13/69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (saw) view the body after death.   |                      |  |   |
| 23A. SIGNATURE <b>Earl Pass</b>  |                      | 23B. DATE SIGNED <b>10/14/69</b>   |   |
| 23C. PHYSICIAN'S NAME (Type) <b>EARL PASS</b>  |                      | 23D. ADDRESS <b>4001 Welches Ave</b>   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |                      | 24B. DATE <b>10/15/69</b>  |   |
| 24C. NAME OF CEMETERY or CREMATORY <b>MEADOWRIDGE</b>  |                      | 24D. LOCATION (City, town, or county) (State) <b>HOWARD Co.</b>  |   |
| 25A. DATE REC'D BY HEALTH DEPT. <b>OCT 30 1969</b>   |                      | 25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>   |   |
| 25C. FUNERAL DIRECTOR <b>H.W. MEARS &amp; SON</b>  |                      | ADDRESS <b>805 N. CALVERT ST.</b>  |   |

Letter from Dr. J. Carl Pass  
10-30-69 M.H.

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |                     |   |                                    | REG. NO. <b>69 10674</b>   |   |
|--|---------------------|---|------------------------------------|--|---|
| 69 10674   |                     |   |                                    | CERTIFICATE OF DEATH   |   |
| BIRTH NO.  |                     | 1. NAME OF DECEASED<br>(Type or Print) <b>Butler, Carl</b>  |                                    | 2. DATE AND HOUR OF DEATH<br><b>10/26/69 @ 5:45</b>                                |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                     | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Maryland</b><br>8. COUNTY <b>605</b>                   |                                    | M.   |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Johns Hopkins Hosp</b>  |                     | C. CITY OR TOWN<br><b>Baltimore</b>   |                                    | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| E. STREET AND NUMBER<br><b>238 Beale Court</b>   |                     |   |                                    |  |   |
| 5. SEX<br><b>M</b>   | 6. RACE<br><b>N</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12/3/02</b> | 9. AGE (In years lost birthday)<br><b>66</b>                                       | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>  |                     | 10B. KIND OF BUSINESS OR INDUSTRY   |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>MD.</b>                            |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |                     |   |                                    |  |   |
| 13. FATHER'S NAME<br><b>Alexander Butler</b>   |                     | 14. MOTHER'S MAIDEN NAME<br><b>Anna Bell Mondowney</b>  |                                    |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |                     | 16. SOCIAL SECURITY NO.   |                                    | 17. INFORMANT<br><b>Edith Butler</b>   |   |
| 18. <b>153,81</b>  |                     | CAUSE OF DEATH  |                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                       |   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   |                     | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Emaciation &amp; Dehydration</b>   |                                    | <b>2 weeks</b>   |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                     | (B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>Colonic Obstruction</b>   |                                    | <b>2 weeks</b>   |   |
|  |                     | (C) <b>Adenocarcinoma of Colon</b>  |                                    | <b>3 yrs</b>   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (A).  |                     |   |                                    |  |   |
| 19A. DATE OF OPERATION<br><b>10/10/69</b>  |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Colonic Obstruction</b>  |                                    | 20A. AUTOPSY? (Yes or No) <b>N</b>   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)           |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                                    | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10/10/69</b> to <b>10/26/69</b> and that (I) (we) last saw the deceased alive on <b>10/25/69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                     |   |                                    |  |   |
| 23A. SIGNATURE<br><b>DM Haines</b>   |                     | 23B. DATE SIGNED<br><b>10/26/69</b>   |                                    | 23C. PHYSICIAN'S NAME (Type)<br><b>DM Haines MD</b>                                |   |
| 23D. ADDRESS<br><b>Johns Hopkins Hospital</b>  |                     |   |                                    |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                     | 24B. DATE<br><b>Oct 30/69</b>   |                                    | 24C. NAME of CEMETERY or CREMATORY<br><b>Westport Md.</b>                          |   |
| 24D. LOCATION (City, town, or county) (State)  |                     |   |                                    |  |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 30 1969</b>  |                     | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, R.D.</b>   |                                    | 25C. FUNERAL DIRECTOR<br><b>Frank E. Eubank 11297, Columbia St</b>                 |   |

2. 10. 1912  
2. 10. 1912

James Hopkins H. 26

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V-525

## BALTIMORE CITY HEALTH DEPARTMENT

69 10675

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

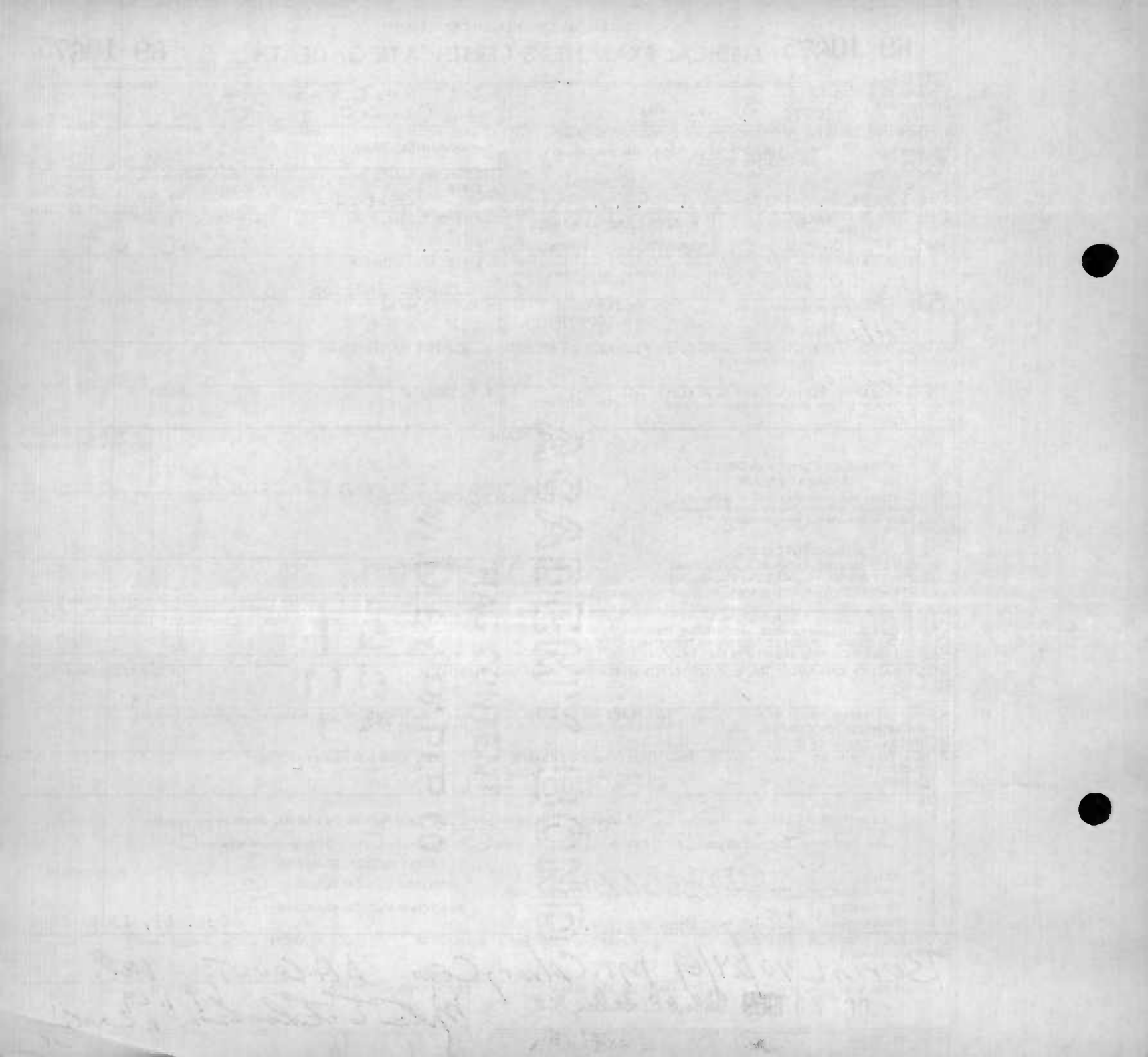
REG. NO.

69 10675

BIRTH NO.

|  |  |   |  |
|--|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>MELVIN S. VINCENT</b>   |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month Day Year Hour<br><b>10 17 69 3:25 a.m.</b>  |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>1224 E. Madison Ave. D.O.A.</b>   |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>October 17, 1969 3:25 a.m.</b>   |  |
| 6. SEX<br><b>Male</b>  |  | 7. RACE<br><b>Negro</b>   |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | C. CITY OR TOWN<br><b>Balto.</b>  |  |
| 9. DATE OF BIRTH<br><b>Sept 13, 1918</b>   |  | 10. AGE (In years lost birthday)<br><b>51</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Ind.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>  |  | 14B. KIND OF BUSINESS OR INDUSTRY   |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  | 17. SOCIAL SECURITY NO.   |  |
| 18. INFORMANT<br><b>Records</b>  |  | ADDRESS   |  |
| 19. <b>4367 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <b>Intracerebral hemorrhage</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) _____<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) _____<br><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 20A. DATE OF OPERATION<br><b>2</b>   |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?   |  | 22F. HOW DID INJURY OCCUR?  |  |
| 22D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |
| 23.<br>I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br><br>ACTUAL SIGNATURE <b>Isidore Mihalakis</b> M.D.<br>EXAMINER'S NAME (Type) <b>Isidore Mihalakis, M.D.</b><br><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br><br>DATE SIGNED <b>Oct. 17, 1969</b> |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>10/24/69</b>  |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Mt. Calvary Cem.</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>AA. County Md.</b>  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 30 1969</b>  |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher, M.D.</b>   |  |
| 25C. FUNERAL DIRECTOR<br><b>Walter E. Erickson</b>   |  | ADDRESS<br><b>1129 N. Carroll St.</b>   |  |







# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY CITY HEALTH DEPARTMENT  |  |  |  | 69 10676  |  |   |  |
|--|--|--|--|---|--|---|--|
| 69 10676   |  |  |  | CERTIFICATE OF DEATH  |  |   |  |
| BIRTH NO.  |  |  |  | REG. NO.  |  |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Mc Gee, William</i>  |  |  |  | 2. DATE AND HOUR OF DEATH <i>10/26/69 12:30 PM</i>  |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)   |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><i>Key Circle Hospice</i>   |  |  |  | A. STATE<br><b>Maryland</b>   |  | B. COUNTY   |  |
|  |  |  |  | C. CITY OR TOWN<br><b>Baltimore</b>   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 5. SEX <i>Male</i>   |  |  |  | 6. RACE <i>Colored</i>  |  |   |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  | 8. DATE OF BIRTH <i>6/15/83</i>   |  |   |  |
| 9. AGE (In years last birthday) <i>86 yrs.</i>   |  |  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Retired Solder</i>             |  |   |  |
| 11. BIRTHPLACE (State or foreign country)<br><i>North Carolina</i>   |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  |
| 13. FATHER'S NAME<br><b>Jessie McGee</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Katy</b>   |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Unknown</b>   |  |  |  | 16. SOCIAL SECURITY NO.   |  |   |  |
| 17. INFORMANT<br><b>Jessie McGee 1225 N Spring St.</b>   |  |  |  | ADDRESS   |  |   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><i>4/20/1</i>  |  |  |  | CAUSE OF DEATH  |  |   |  |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |  |  |  | (A) IMMEDIATE CAUSE<br><i>Cordian Arrest.</i>   |  |   |  |
|  |  |  |  | (B) <i>A.S.H.O.</i>   |  |   |  |
|  |  |  |  | (C) <i>Hypertension</i>   |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |
| 19A. DATE OF OPERATION   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>10-25</i> 19 <i>69</i> to <i>10-26</i> 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>10-26</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 23A. SIGNATURE<br><i>[Signature]</i>   |  |  |  | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |  | 23B. DATE SIGNED<br><i>10-27-69</i>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><i>terhouse</i>  |  |  |  | 23D. ADDRESS<br><i>5428 Sinclair La. Balto. Md. 21206</i>   |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |  | 24B. DATE<br><i>10/31/69</i>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><i>Mt. Calvary Cemetery</i>   |  | 24D. LOCATION (City, town, or county) (State)<br><i>A.A. County Md.</i>                       |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>OCT 30 1969</i>  |  | 25B. NAME OF REGISTRAR<br><i>Robert E. Fisher, R.D.</i>  |  | 25C. FUNERAL DIRECTOR<br><i>Frank T. Elchman</i>  |  | ADDRESS<br><i>1129 N. Central</i>   |  |

Key Circle Mapping  
Male (date) 11/12/83  
West Circle

1  
T-510

69 10677

BALTIMORE CITY HEALTH DEPARTMENT

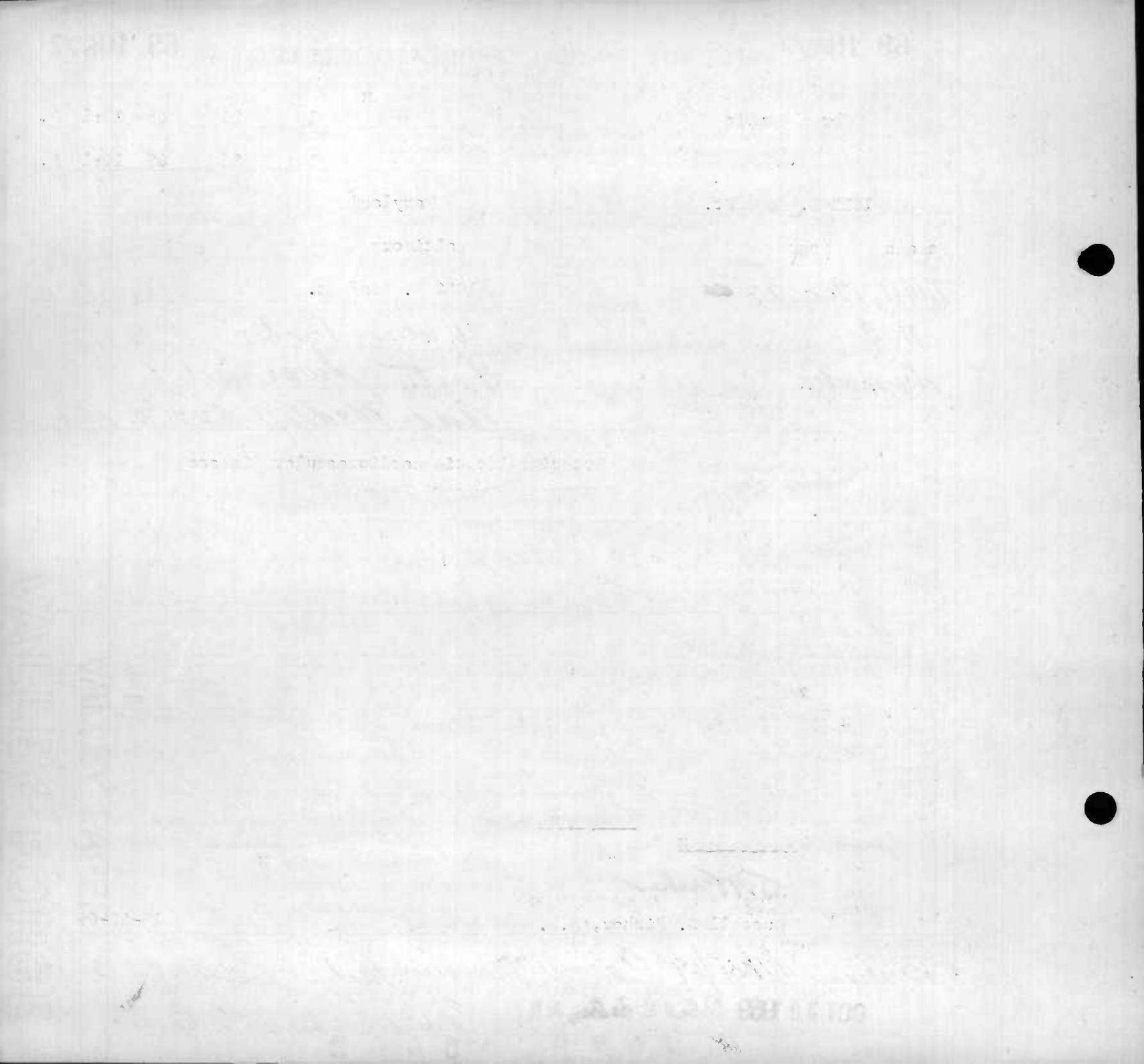
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 10677

BIRTH NO.

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Ebron Temple</b>  |  |  |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month <b>10</b> Day <b>26</b> Year <b>69</b> Hour <b>10:10 A.M.</b><br>Estimated <input type="checkbox"/>  |  |  |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>1822 N. Bond St.</b>  |  |  |  | 3. DATE PRONOUNCED DEAD<br>Month <b>10</b> Day <b>26</b> Year <b>69</b> Hour <b>10:10 A.M.</b>   |  |  |  |
| 6. SEX <b>Female</b>  |  |  |  | 7. RACE <b>Negro</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. DATE OF BIRTH <b>Nov 11, 1906</b>  |  |  |  | 10. AGE (In years last birthday) <b>63</b>   |  | 11. BIRTHPLACE (State or foreign country) <b>D.C.</b>  |  |
| 12. CITIZEN OF WHAT COUNTRY?  |  |  |  | 13. FATHER'S NAME <b>Walter Baker</b>  |  | 14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>806</b>          |  |
| 15. MOTHER'S MAIDEN NAME <b>Lucy Swann</b>  |  |  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  |  |  |  |
| 17. SOCIAL SECURITY NO.   |  |  |  | 18. INFORMANT ADDRESS <b>Adm. Maddox 1822 N. Bond St.</b>  |  |  |  |
| 19. <b>4 12 4</b> CAUSE OF DEATH<br><b>Arteriosclerotic cardiovascular disease</b><br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) |  |  |  |  |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |  |  |  |  |  |  |  |
| 20A. DATE OF OPERATION  |  |  |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |
| 21. AUTOPSY? (Yes or No) <b>no</b>  |  |  |  | 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |  |  |
| 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |  |  | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?   |  |  |  |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)  |  |  |  | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  |
| 22F. HOW DID INJURY OCCUR?  |  |  |  | 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |
| ACTUAL SIGNATURE <b>Russell S. Fisher</b> M.D.<br>EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>   |  |  |  | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>   |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>  |  |  |  | 24B. DATE <b>Oct 30/69</b>   |  |  |  |
| 24C. NAME OF CEMETERY or CREMATORY <b>Carver Memorial Park</b>  |  |  |  | 24D. LOCATION (City, town, or county) (State) <b>Laurel Md.</b>  |  |  |  |
| 25A. DATE REC'D BY HEALTH DEPT. <b>OCT 30 1969</b>  |  |  |  | 25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>   |  |  |  |
| 25C. FUNERAL DIRECTOR <b>John T. Elickson</b>   |  |  |  | ADDRESS <b>129 N. Caroline St.</b>   |  |  |  |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

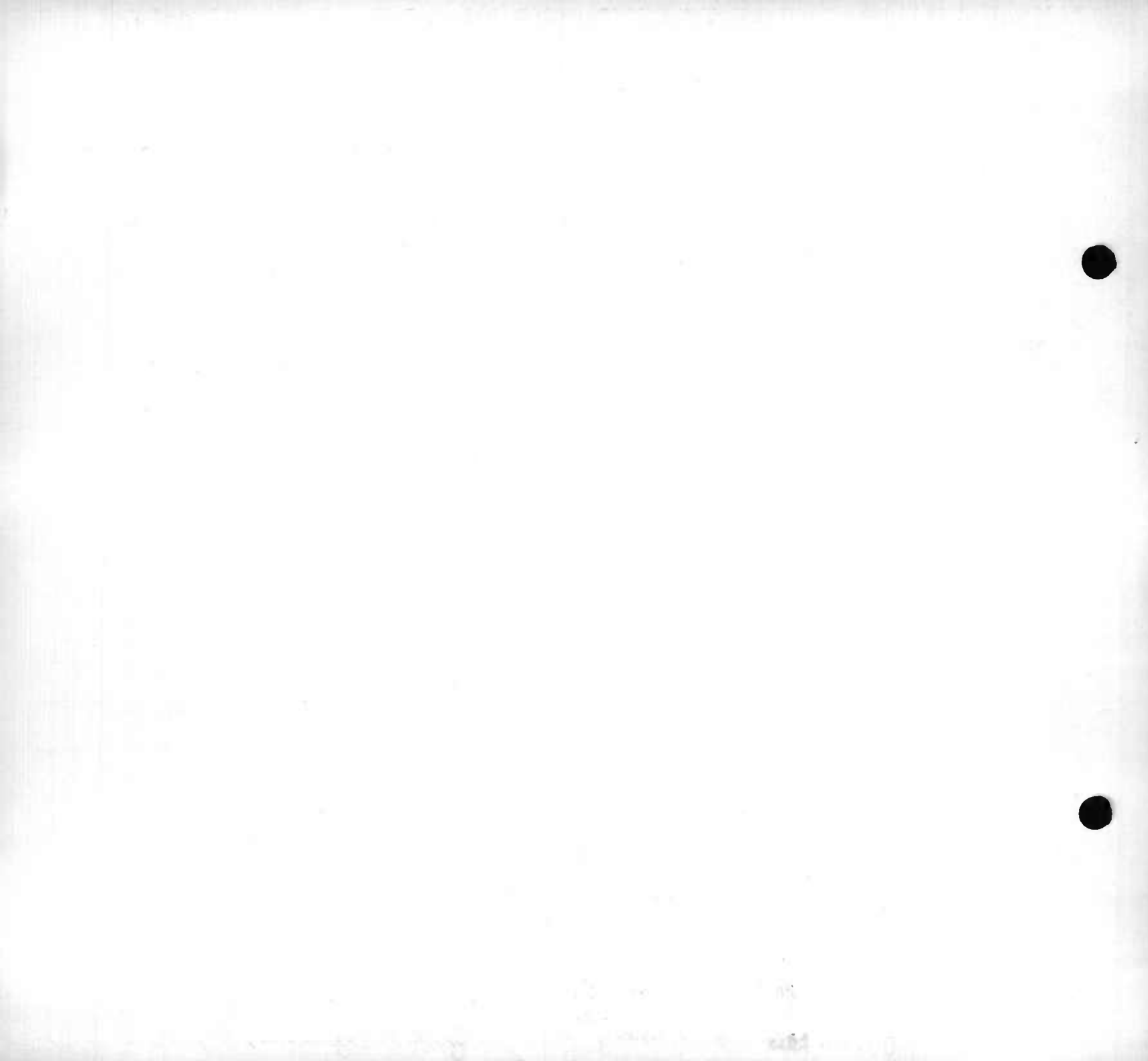
m-6321

69 10678

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 10678

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| BIRTH NO.  |  | 1. NAME OF DECEASED<br>(Type or Print) <b>MARY MURDOCK</b>   |  | 2. DATE AND HOUR OF DEATH<br><b>10/26/69 9:20 p.m.</b>  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>1538</b> |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>UNIVERSITY OF MARYLAND HOSPITAL</b>   |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |  | C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |
| 5. SEX <b>F</b> 6. RACE <b>NEGRO</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>3/28/04</b> 9. AGE (In years last birthday) <b>65</b>   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>  |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>   |  |
| 13. FATHER'S NAME<br><b>NOT AVAILABLE</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>NOT AVAILABLE</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>  |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT <b>SISTER</b> ADDRESS   |  |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>MENINGITIS?</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>STAPHYLOCOCCAL SEPTICEMIA</b><br><b>URINARY TRACT INFECTION</b> |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 DAY</b><br><b>4 DAYS</b><br><b>10 DAYS</b>   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>ATRIAL FIBRILLATION, CONGESTIVE FAILURE, PULMONARY EDEMA, RIGHT MIDDLE CEREBRAL CVA.</b>  |  |  |  |   |  |
| 19A. DATE OF OPERATION <b>0</b>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No) <b>NO</b>   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10/16/69</b> to <b>10/26/69</b> that (I) (we) last saw the deceased alive on <b>10/26/69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |  |  |  |   |  |
| 23A. SIGNATURE <b>A. M. Wale</b>   |  |  |  | 23B. DATE SIGNED <b>10/26/69</b>  |  |
| 23C. PHYSICIAN'S NAME (Type) <b>DEGREE</b>   |  |  |  | 23D. ADDRESS  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 24B. DATE <b>10/30/69</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY <b>Garden of Eternal Hope</b>  |  |
| 24D. LOCATION (City, town, or county) <b>Farmington Md.</b>  |  | 24E. NAME OF REGISTRAR <b>Robert E. Taylor, R.D.</b>   |  | 24F. FUNERAL DIRECTOR <b>Walter E. Elshorn</b> ADDRESS <b>11297 Caroline St.</b>  |  |



1  
C-125

69 10679

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 10679

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MATRILLA GIBSON

2. DATE OF DEATH Known ☒ Estimated ☐ Month Day Year Hour  
10 24 69 12:05 pm

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Johns Hopkins Hospital D.O.A.

3. DATE PRONOUNCED DEAD Month Day Year Hour  
Oct. 24 1969 12:05 p

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

704

6. SEX 7. RACE 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐  
Female Negro

C. CITY OR TOWN D. INSIDE CITY LIMITS?  
Balto. YES ☐ NO ☐

9. DATE OF BIRTH 10. AGE (In years lost birthday) 11. BIRTHPLACE (State or foreign country)  
Sept 13 1914 55 N.C.

E. STREET AND NUMBER  
1539 E. Madison St.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME  
Unknown

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
Housewife

15. MOTHER'S MAIDEN NAME  
Unknown

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO. 18. INFORMANT ADDRESS  
Magnolia Ingram 1907 Calhoun

19. 571.9 I CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Cirrhosis of the liver  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No)  
No

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY (APPROX.) 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 22F. HOW DID INJURY OCCUR?

23. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Tsidore Mihalakis, M.D.

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED

24A. BURIAL CREMATION, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETERY or CREMATORY 24D. LOCATION (City, town, or county) (State)  
Burial Oct 31 1969 Mt Auburn Cem Westport md.

25A. DATE REC'D BY HEALTH DEPT. 25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR ADDRESS  
OCT 30 1969 Robert E. Taylor, Jr. Milton E. Chickaw 1129 N. Carroll





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 10680

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 69 10680

|  |                       |   |                                       |  |   |
|--|-----------------------|---|---------------------------------------|--|---|
| BIRTH NO.  |                       | 1. NAME OF DECEASED<br>(Type or Print) <i>Anna Goodbloss Ware</i>   |                                       | 2. DATE AND HOUR OF DEATH<br><i>October 21, 1969 6 A. M.</i>                       |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                       | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <i>MD.</i> B. COUNTY <i>1606</i>  |                                       |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><i>002801 Raynor ave</i>  |                       | C. CITY OR TOWN<br><i>Baltimore</i>   |                                       | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
|  |                       | E. STREET AND NUMBER<br><i>2801 Raynor Ave Bldg 16</i>  |                                       |  |   |
| 5. SEX<br><i>F.</i>  | 6. RACE<br><i>Ch.</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                 | 8. DATE OF BIRTH<br><i>12/24/1900</i> | 9. AGE (In years last birthday)<br><i>69</i>                                       | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>  |                       | 10B. KIND OF BUSINESS OR INDUSTRY   |                                       | 11. BIRTHPLACE (State or foreign country)<br><i>WA</i>                             |   |
| 13. FATHER'S NAME<br><i>Unknown</i>  |                       | 14. MOTHER'S MAIDEN NAME<br><i>Unknown</i>  |                                       | 12. CITIZEN OF WHAT COUNTRY?   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |                       | 16. SOCIAL SECURITY NO.   |                                       | 17. INFORMANT<br><i>Beulah Barker 2801 Raynor Ave</i>                              |   |
| 18. <i>412.4 I</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                       | CAUSE OF DEATH<br><i>A.S.C.V.D.</i><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF: |                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                       |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                       |   |                                       |  |   |
| 19A. DATE OF OPERATION   |                       | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                       | 20A. AUTOPSY? (Yes or No)  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                       | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                       | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)           |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                       | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                                       | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9-26-1969</i> to <i>10-21-1969</i> , that (I) (we) lost saw the deceased alive on <i>10-20-1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                    |                       |   |                                       |  |   |
| 23A. SIGNATURE<br><i>Barbu Calin</i>   |                       | DEGREE<br>Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>                                   |                                       | 23B. DATE SIGNED<br><i>10-28-69</i>  |   |
| 23C. PHYSICIAN'S NAME (Type)<br><i>BARBU CALIN</i>   |                       | 23D. ADDRESS<br><i>831 Poplar Grove Baltimore</i>   |                                       |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |                       | 24B. DATE<br><i>Oct 24/69</i>   |                                       | 24C. NAME OF CEMETERY or CREMATORY<br><i>Arbutus New Park Arbutus Md.</i>          |   |
| 24D. LOCATION (City, town, or county) (State)  |                       | 24E. FUNERAL DIRECTOR<br><i>Joseph E. Gluck 1129 N. Carroll St.</i>   |                                       |  |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>OCT 30 1969</i>  |                       | 25B. NAME OF REGISTRAR<br><i>Robert E. Taylor</i>   |                                       | 25C. FUNERAL DIRECTOR ADDRESS  |   |



69 10681  
BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
REG. NO. 69 10681

|  |                         |   |   |   |  |
|--|-------------------------|---|---|---|--|
| BIRTH NO.  |                         | 1. NAME OF DECEASED<br>(Type or Print) <b>TENNIE SUMPTER</b>  |   | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> M.                         |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>00 1134 W. Lexington Street (DOA)</b>   |                         | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>October 29, 1969 1:35 A.M.</b>   |   | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>1802</b> |  |
| 6. SEX<br><b>Male</b>  | 7. RACE<br><b>Negro</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | C. CITY OR TOWN<br><b>Baltimore</b>                     |   | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 9. DATE OF BIRTH<br><b>4/11/18</b>   |                         | 10. AGE (In years lost birthday) <b>51</b>  | E. STREET AND NUMBER<br><b>1134 W. Lexington Street</b> |   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>South Carolina</b>   |                         | 12. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  | 13. FATHER'S NAME<br><b>James Sumter</b>                |   |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>  |                         | 14B. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>  | 15. MOTHER'S MAIDEN NAME<br><b>Emma Fisher</b>          |   |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>   |                         | 17. SOCIAL SECURITY NO.   | 18. INFORMANT ADDRESS<br><b>Mrs Ethel Sumter, same</b>  |   |  |
| 19. <b>412.4</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Arteriosclerotic Cardiovascular Disease</b>   |                         | CAUSE OF DEATH  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |                         | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:  |   |   |  |
|  |                         | (B) DUE TO, OR AS A CONSEQUENCE OF:   |   |   |  |
|  |                         | (C) DUE TO, OR AS A CONSEQUENCE OF:   |   |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                         |   |   |   |  |
| 20A. DATE OF OPERATION   |                         | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 21. AUTOPSY? (Yes or No)<br><b>no</b>   |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                         | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |
| 22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)  |                         | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 22F. HOW DID INJURY OCCUR?  |  |
| 23.<br>I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D.<br>EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED <b>10/29/69</b> |                         |   |   |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 24B. DATE<br><b>11/1/69</b>   |   | 24C. NAME of CEMETERY or CREMATORY<br><b>Mr. Auburn Cemetery</b>  |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore Md</b>   |                         | 25A. DATE RECEIVED BY FUNERAL DIRECTOR<br><b>OCT 30 1969</b>  |   |   |  |
| 25B. FUNERAL DIRECTOR ADDRESS<br><b>Adolphus Halstead 1206 W North Ave</b>   |                         |   |   |   |  |

1801 80

WALLEY POHSE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                     |   |  |  |  |   |  |
|--|---------------------|---|--|--|--|---|--|
| D-624  |                     | 69 10682  |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | REG. NO. 69 10682   |  |
| BIRTH NO. (JOHN B. DRASAL)   |                     |   |  | CERTIFICATE OF DEATH   |  |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>DRASAL, JOHN R.</b>  |                     |   |  | 2. DATE AND HOUR OF DEATH<br><b>10-29-69 11:30 AM</b>  |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><b>JOHNS HOPKINS HOSPITAL</b>  |                     |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>33</b>  |                     |   |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |  | C. CITY OR TOWN<br><b>BALTIMORE CITY</b>  |  |
|  |                     |   |  |  |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
|  |                     |   |  | E. STREET AND NUMBER<br><b>733 N LAKEWOOD AVE.</b>   |  |   |  |
| 5. SEX<br><b>M</b>   | 6. RACE<br><b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Apr. 30, 1921</b>   |  | 9. AGE (In years last birthday)<br><b>48 Years</b>  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Truck loader</b>   |                     | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Motor Frgt. Co.</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Frank Joseph Drasal</b>  |                     |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Camilla Morkowsky</b>   |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces?<br>(Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes World War 11</b>   |                     | 16. SOCIAL SECURITY NO.<br><b>213-18-3318</b>   |  | 17. INFORMANT<br><b>Mrs. Donna M. Drasal-733 N. Lakewood Ave</b>   |  |   |  |
| 18. <b>430.9 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Ruptured Intracranial Aneurysm</b>  |                     |   |  | CAUSE OF DEATH   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>15 days</b>                                |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                     |   |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>-</b>  |  |   |  |
|  |                     |   |  | (B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>-</b>  |  |   |  |
|  |                     |   |  | (C) DUE TO, OR AS A CONSEQUENCE OF:<br><b>-</b>  |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>-</b>   |                     |   |  |  |  |   |  |
| 19A. DATE OF OPERATION<br><b>10-29-69</b>  |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Bleeding Intracranial Aneurysm</b>   |  | 20A. AUTOPSY? (Yes or No)<br><b>No</b>   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)  |  |   |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?   |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Oct. 14-69</b> 1969 to <b>Oct 29</b> 1969, that (I) (we) last saw the deceased alive on <b>10-29-69</b> 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                     |   |  |  |  |   |  |
| 23A. SIGNATURE<br><b>Humberto D. Elara</b>   |                     |   |  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>              |  | 23B. DATE SIGNED<br><b>10-29-69</b>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Humberto D. Elara, M.D.</b>   |                     |   |  | 23D. ADDRESS<br><b>The Johns Hopkins Hospital</b>  |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Cremation</b>   |                     | 24B. DATE<br><b>Oct. 30, '69</b>  |  | 24C. NAME of CEMETERY or CREMATORY<br><b>Greenmount Crematory</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>                   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 30 1969</b>  |                     | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor</b>   |  | 25C. FUNERAL DIRECTOR ADDRESS<br><b>H. Sander &amp; Sons, Inc. Balto., Md.</b>   |  |   |  |

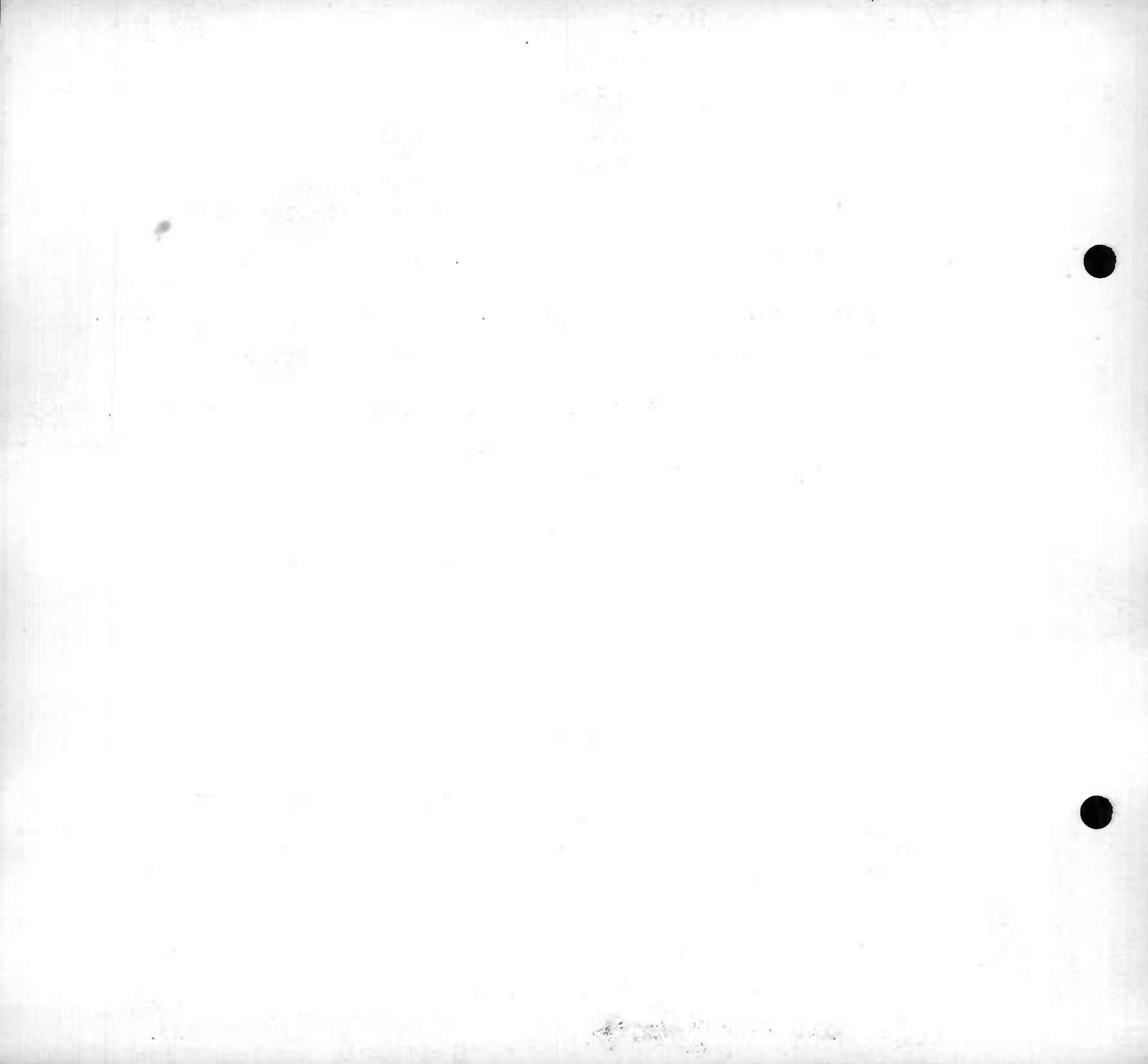
*Dates of operations*  
11/3/69 - 10/14/69 - Cerebral arteriogram

10/27/69 - Angiogram -

Information via phone from JHH - w/ed Records  
K.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| H-360  |  | 69 10683   |  | BALTIMORE CITY HEALTH DEPT. ENT  |  | REG. NO. 69 10683  |  |
| BIRTH NO.  |  |  |  | CERTIFICATE OF DEATH   |  |  |  |
| 1. NAME OF DECEASED (Type or Print) HARRY LOUIS HUETHER  |  |  |  | 2. DATE AND HOUR OF DEATH 10/30/69 13:35 A. M.   |  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)  |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION 37 MERCY HOSPITAL   |  |  |  | A. STATE Maryland  |  |  |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |  |  |  | C. CITY OR TOWN Baltimore  |  |  |  |
|  |  |  |  | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
|  |  |  |  | E. STREET AND NUMBER 4300 North Charles Street   |  |  |  |
| 5. SEX Male  |  | 6. RACE White  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH Nov. 9, 1900  |  |
|  |  |  |  | 9. AGE (in years last birthday) 68   |  | 10. If Under 1 Yr. Months: Days: Hours: Min.                         |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager Partner  |  |  |  | 10B. KIND OF BUSINESS OR INDUSTRY Independent Can Co. Maryland   |  |  |  |
| 11. BIRTHPLACE (State or foreign country) Maryland   |  |  |  | 12. CITIZEN OF WHAT COUNTRY? U.S.A.  |  |  |  |
| 13. FATHER'S NAME Conrad Huether   |  |  |  | 14. MOTHER'S MAIDEN NAME Martha Revere   |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO 216 32 3531  |  |  |  | 16. SOCIAL SECURITY NO.  |  |  |  |
|  |  |  |  | 17. INFORMANT Mrs Martha May Huether 4300 N. Charles   |  |  |  |
| 18. CAUSE OF DEATH   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH   |  |  |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Congestive heart failure, irreversible   |  |  |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   |  |  |  | (B) DUE TO, OR AS A CONSEQUENCE OF: CVD Atherosclerotic + Coronary Artery Disease  |  |  |  |
| ANTECEDENT CAUSES  |  |  |  | (C) Diabetes Mellitus  |  |  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  |  |  |  |  |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |  |  |  |  |  |  |
| 19A. DATE OF OPERATION   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No) No   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |  |  |
| 21D. TIME OF INJURY (APPROX.)  |  | 21E. INJURY OCCURRED   |  | 21F. HOW DID INJURY OCCUR?   |  |  |  |
| (Month) (Day) (Year) (Hour)  |  | White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>        |  |  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from Sept. 8 19 69 to Oct 30 19 69 that (I) (we) last saw the deceased alive on Oct 30 19 69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 23A. SIGNATURE A. J. Hipolito, M.D.  |  |  |  | 23B. DATE SIGNED   |  |  |  |
| 23C. PHYSICIAN'S NAME (Type) A. J. Hipolito M.D.   |  |  |  | 23D. ADDRESS Mercy Hospital  |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Entombment  |  | 24B. DATE 11/1/69  |  | 24C. NAME of CEMETERY or CREMATORY Lorraine Mausoleum  |  | 24D. LOCATION (City, town, or county) Woodlawn Maryland              |  |
| 25A. DATE REC'D BY HEALTH DEPT. OCT 30 1969  |  | 25B. NAME OF REGISTRAR   |  | 25C. FUNERAL DIRECTOR Henry Sander & Sons Inc.   |  | ADDRESS  |  |

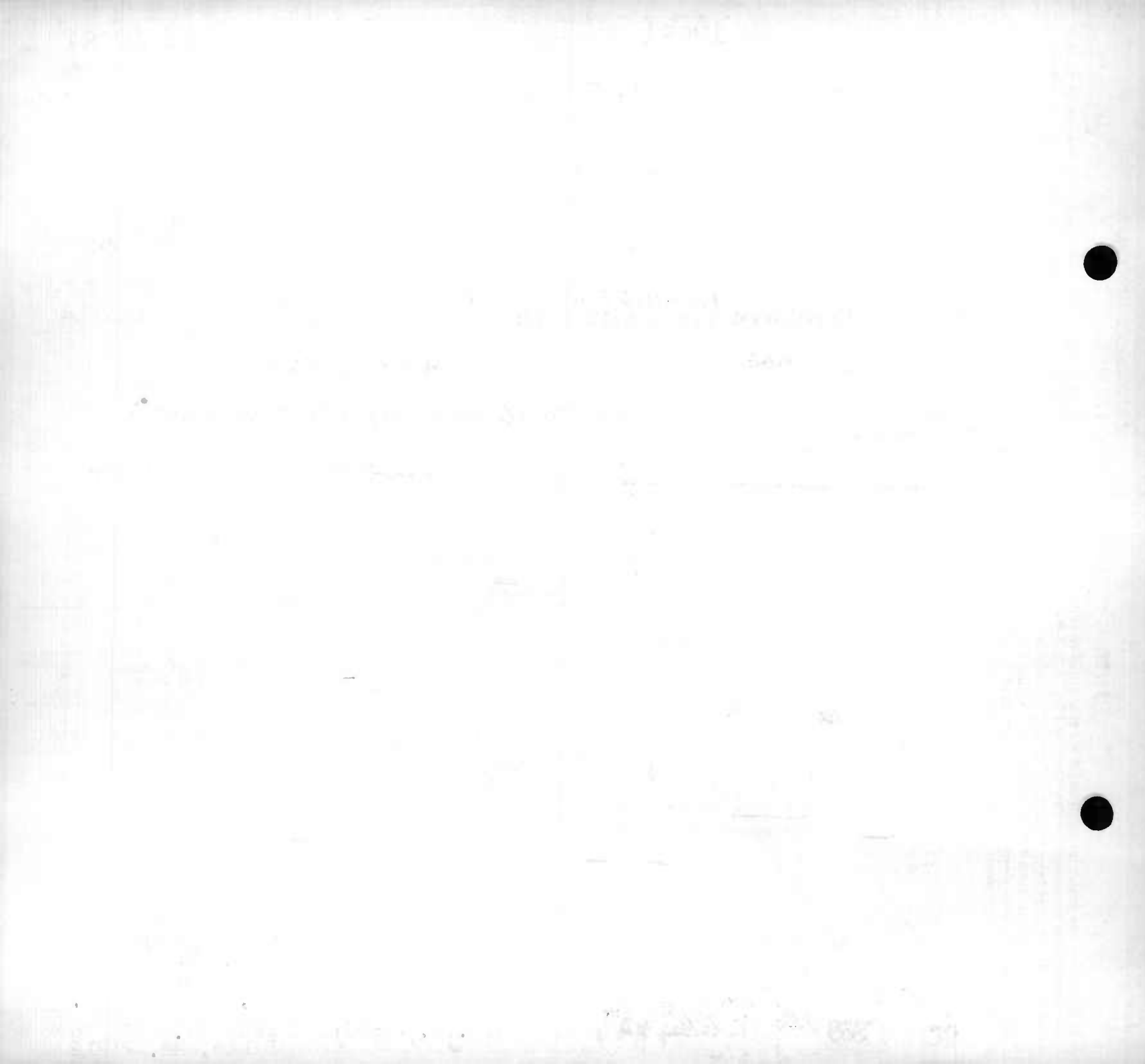




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

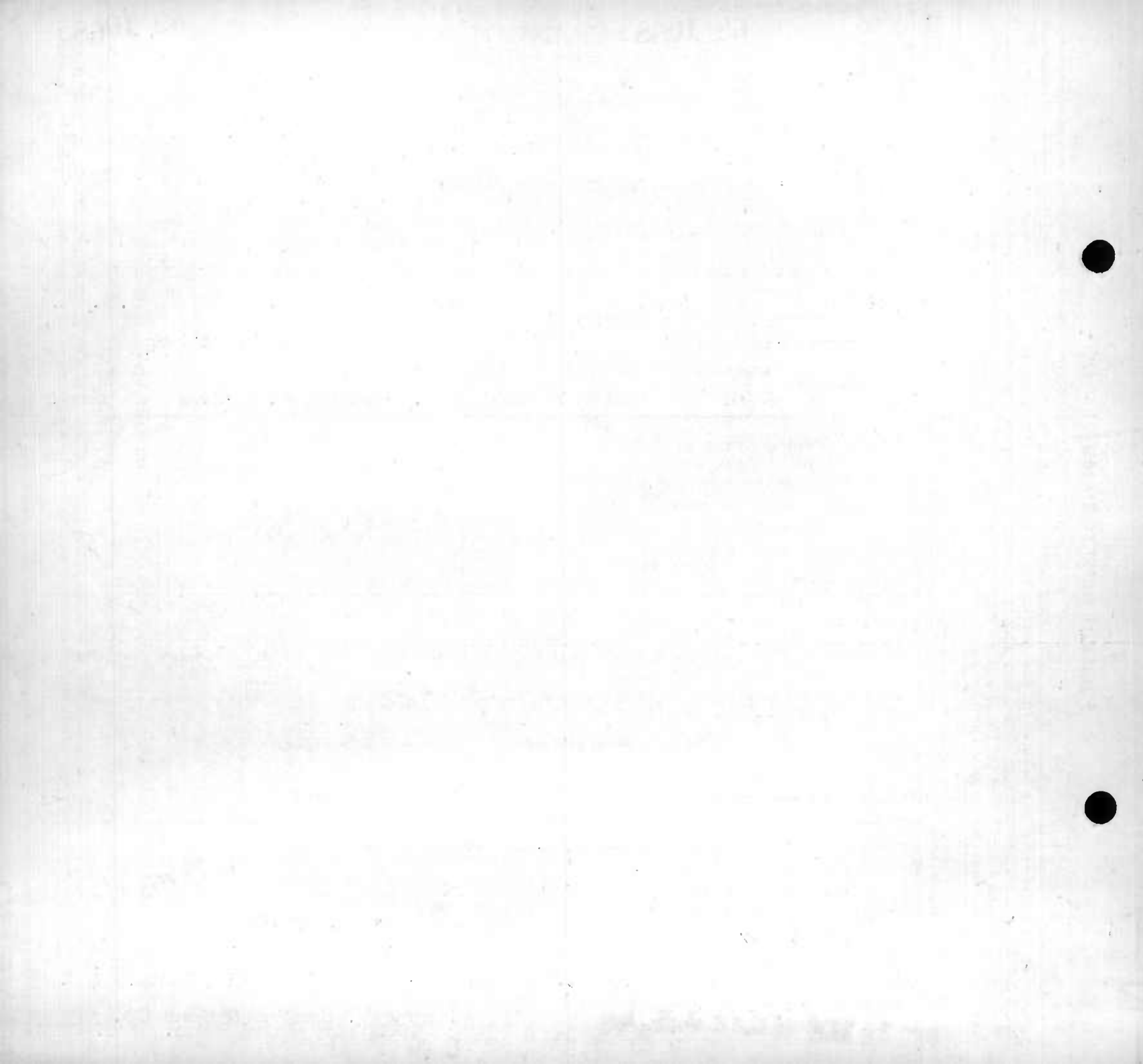
|  |              |   |  |   |                                       |   |  |
|--|--------------|---|--|---|---------------------------------------|---|--|
| E-520  |              | 69 10684  |  | BALTIMORE CITY HEALTH DEPARTMENT  |                                       | REG. NO. 69 10684   |  |
| BIRTH NO.  |              |   |  | 1   |                                       |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) WILLIAM C. EMGE   |              |   |  | 2. DATE AND HOUR OF DEATH<br>10-29-69 11:00 P.M.  |                                       |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |              |   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE MARYLAND B. COUNTY 2741 |                                       |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>44 UNION MEMORIAL HOSPITAL  |              |   |  | C. CITY OR TOWN BALTIMORE   |                                       | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
|  |              |   |  | E. STREET AND NUMBER<br>3313 GREENTON AVE.  |                                       |   |  |
| 5. SEX<br>M  | 6. RACE<br>W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>09-21-92  | 9. AGE (In years last birthday)<br>77 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                 |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>RETIRED REPAIRMAN   |              | 10B. KIND OF BUSINESS OR INDUSTRY<br>TYPEWRITER CO.   |  | 11. BIRTHPLACE (State or foreign country)<br>BALTIMORE, MARYLAND  |                                       | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |
| 13. FATHER'S NAME<br>HARRY EMGE  |              |   |  | 14. MOTHER'S MAIDEN NAME<br>MARY LIND   |                                       |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No   |              | 16. SOCIAL SECURITY NO.<br>203-03-6966  |  | 17. INFORMANT<br>MAS. MYRTLE A. EMGE (SAME)   |                                       |   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>E887X1<br>[This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.]<br>PNEUMONIA<br>HEART FAILURE<br>ASCVD<br>PACETS<br>DISEASE OF RELUIS                                   |              |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2741  |                                       |   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |              |   |  | (B) FRACTURE OF RIGHT HIP<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C)   |                                       |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |              |   |  |   |                                       |   |  |
| 19A. DATE OF OPERATION<br>0  |              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br>No   |                                       | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input checked="" type="checkbox"/>   |              | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>HOME  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>AT PATIENT'S HOME 2741                        |                                       |   |  |
| 21D. TIME OF INJURY (APPROX.)<br>10/26/69 10:11  |              | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?<br>PATIENT FELL AT HOME  |                                       |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from OCT. 26 19 69 to OCT. 29 19 69 that (I) (we) last saw the deceased alive on OCT. 29 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |              |   |  |   |                                       |   |  |
| 23A. SIGNATURE<br>Josef L. S. Alvario M.D.   |              |   |  | 23B. DATE SIGNED<br>10/29/69  |                                       | 23C. PHYSICIAN'S NAME (Type)<br>JOSEF L. S. ALVARIO M.D.                                      |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial   |              | 24B. DATE<br>11/1/69  |  | 24C. NAME OF CEMETERY OR CREMATORY<br>Baltimore   |                                       | 24D. LOCATION (City, town, or county) IS total<br>Baltimore, Md.                              |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>OCT 30 1969   |              | 25B. NAME OF REGISTRAR<br>Robert E. Taylor, M.D.  |  | 25C. FUNERAL DIRECTOR<br>H. W. Jenkins & Sons Co.   |                                       | ADDRESS<br>4905 York Rd Balto, Md. 21212  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

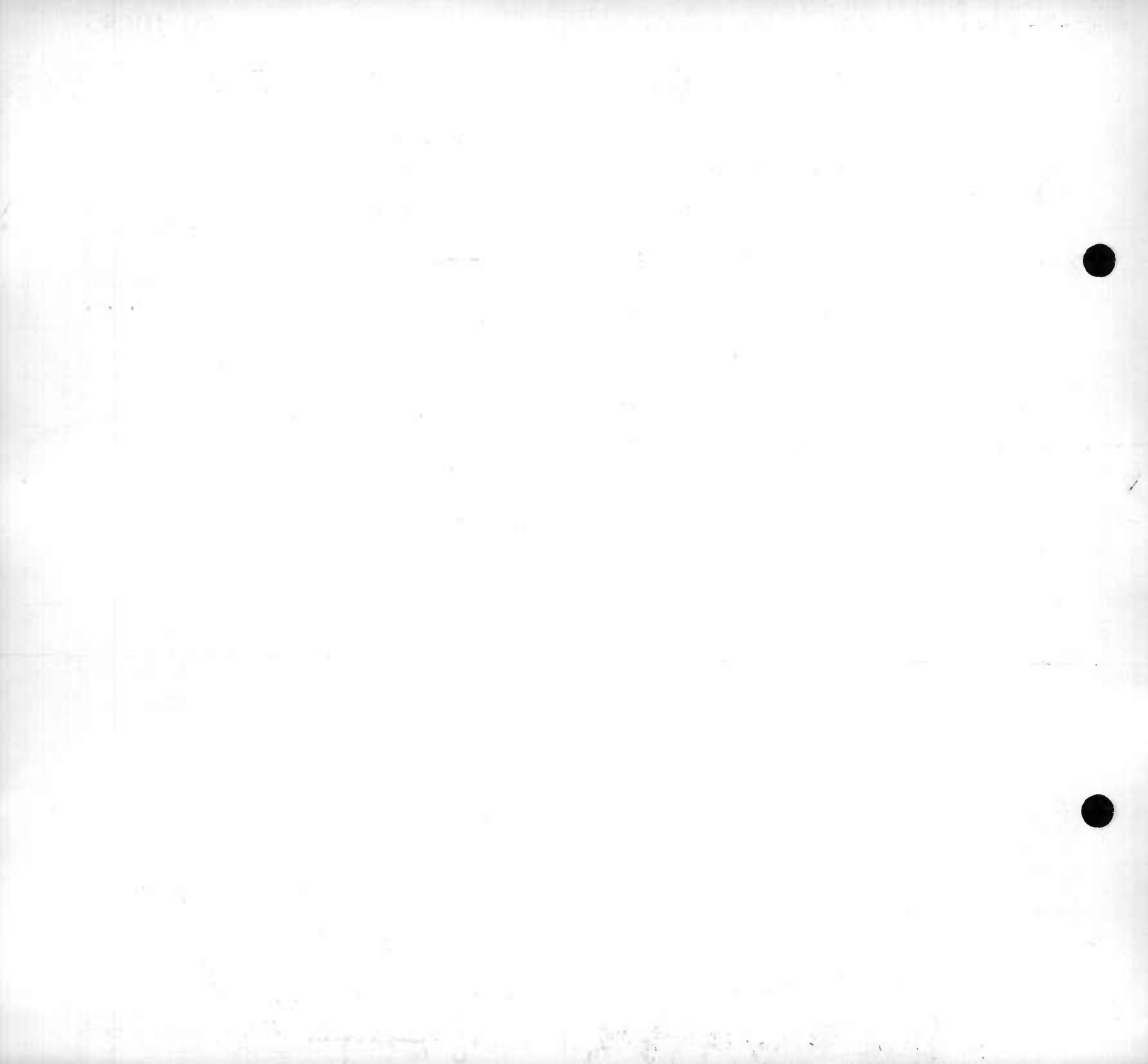
| BALTIMORE CITY HEALTH DEPARTMENT   |                                |   |   | REG. NO. <b>69 10685</b>  |
|--|--------------------------------|---|---|---|
| <div style="display: flex; justify-content: space-between;"> <span><b>5-415</b></span> <span><b>69 10685</b></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>  |                                |   |   |   |
| BIRTH NO.  |                                |   |   |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>DR. MAURICE SULLIVAN</b>   |                                |   | 2. DATE AND HOUR OF DEATH<br><b>10/28/69</b> <b>6 P.</b> M.   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                                |   | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>2713</b> |   |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>8 Midvale Road</b>   |                                |   | C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> ** NO <input type="checkbox"/>                  |   |
| E. STREET AND NUMBER<br><b>8 Midvale Road</b>  |                                |   |   |   |
| 5. SEX<br><b>M</b>   | 6. RACE<br><b>W</b>            | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10-10-1903</b>   | 9. AGE (In years last birthday)<br><b>66</b>                                    |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Physician</b>  |                                |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Medical</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>New Orleans, La.</b>   |                                |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S. A.</b>  |   |
| 13. FATHER'S NAME<br><b>Patrick Sullivan</b>   |                                |   | 14. MOTHER'S MAIDEN NAME<br><b>Rabensteiner</b>   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes WWII</b>  |                                |   | 16. SOCIAL SECURITY NO.<br><b>220-07-4693</b>   |   |
| 17. INFORMANT<br><b>Mrs. Beatrice A. Sullivan</b>  |                                |   | ADDRESS<br><b>Same</b>  |   |
| 18. <b>410.9 I</b> CAUSE OF DEATH  |                                |   |   |   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH   |                                |   |   |   |
| (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)   |                                |   |   |   |
| ANTECEDENT CAUSES  |                                |   |   |   |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                                |   |   |   |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CORONARY THROMBOSIS</b>   |                                |   |   |   |
| (B) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF: <b>3 YRS</b>   |                                |   |   |   |
| (C) _____  |                                |   |   |   |
| II   |                                |   |   |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                                |   |   |   |
| 19A. DATE OF OPERATION<br><b>0</b>   |                                | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)<br><b>No</b>  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)  |                                | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)        |
| 21D. TIME OF INJURY (APPROX.)  |                                | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |   | 21F. HOW DID INJURY OCCUR?  |
| 22. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>DEC. 2, 1947</b> to <b>OCT 28, 1969</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>10/26, 1969</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death. |                                |   |   |   |
| 23A. SIGNATURE<br><b>John M. Scott</b>   |                                |   | 23B. DATE SIGNED<br><b>10/29/69</b>   |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>JOHN M. SCOTT</b>   |                                |   | 23D. ADDRESS<br><b>600 W. BELVEDERE AVE BALTIMORE, MD 21210</b>   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 24B. DATE<br><b>10-30-1969</b> | 24C. NAME of CEMETERY or CREMATORY<br><b>Druid Ridge Cemetery</b>   |   | 24D. LOCATION (City, town, or county) (State)<br><b>Pikesville, Balto., Md.</b> |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 30 1969</b>  |                                | 25B. NAME OF REGISTRAR<br><b>Henry W. Jenkins &amp; Sons Co.</b>  |   | 25C. FUNERAL DIRECTOR ADDRESS<br><b>4905 York Road Balto., Md. 21212</b>        |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

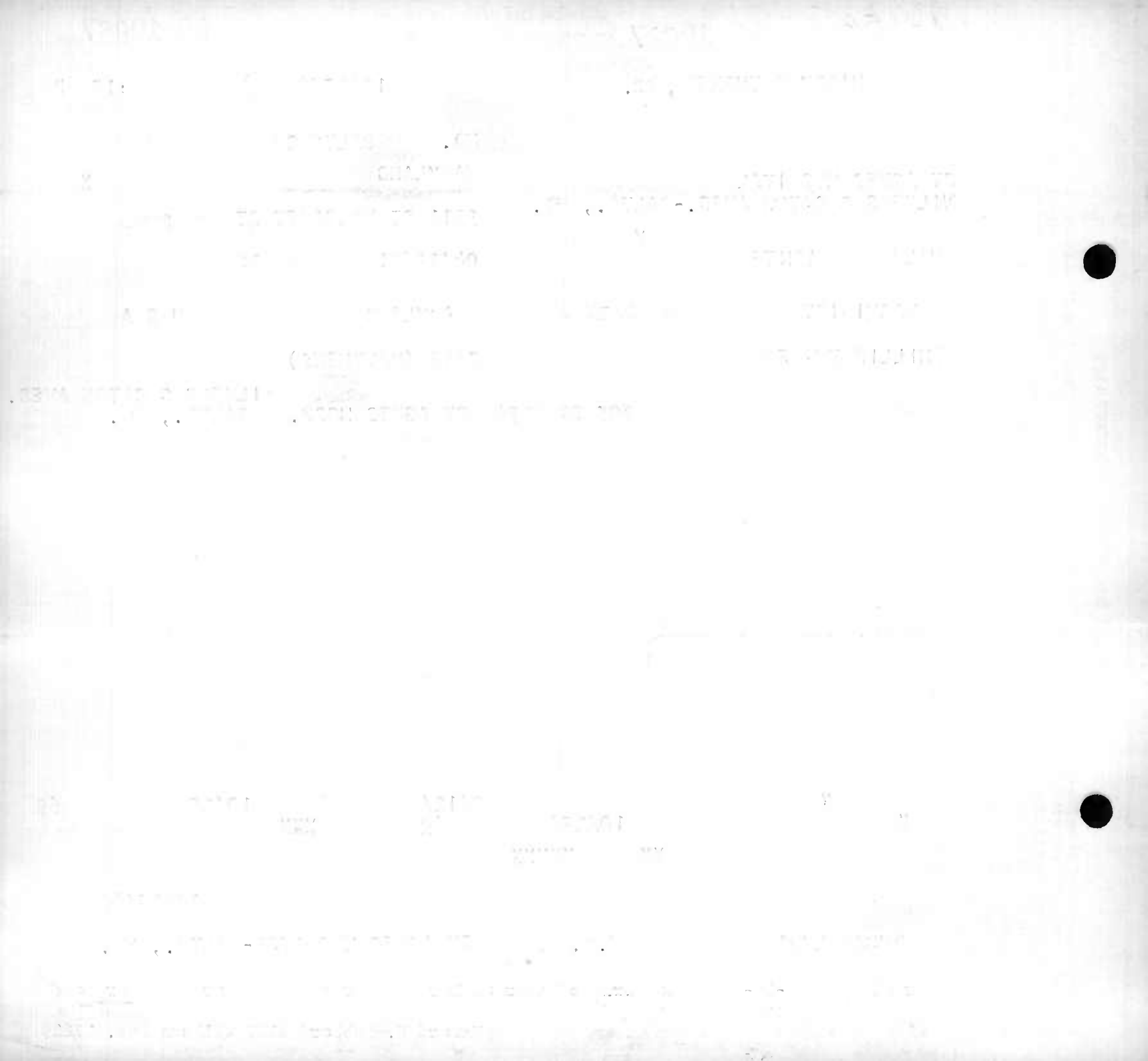
|  |                  |   |                              |   |   |
|--|------------------|---|------------------------------|---|---|
| BIRTH NO.  |                  | BALTIMORE CITY HEALTH DEPARTMENT  |                              | REG. NO. 69 10686   |   |
| 1. NAME OF DECEASED<br>(Type or Print) KATHERINE MEISEL  |                  | 2. DATE AND HOUR OF DEATH<br>OCTOBER 27, 1969 8:40 pm M.  |                              |   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                  | 4. USUAL RESIDENCE (Where deceased lived) If institution: residence before admission  |                              |   |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>31   |                  | IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION<br>Baltimore City Hospitals<br>4940 Eastern Avenue<br>Baltimore, Maryland 21224          |                              | A. STATE<br>Maryland  |   |
|  |                  | C. CITY OR TOWN<br>Baltimore  |                              | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
|  |                  | E. STREET AND NUMBER<br>3505 East Fairmount Avenue 21224  |                              |   |   |
| 5. SEX<br>Female   | 6. RACE<br>White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>7-3-1892 | 9. AGE (In years last birthday)<br>77   | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Homemaker   |                  | 10B. KIND OF BUSINESS OR INDUSTRY   |                              | 11. BIRTHPLACE (State or foreign country)<br>Maryland   |   |
| 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |                  | 13. FATHER'S NAME<br>Foseph Kotwald   |                              | 14. MOTHER'S MAIDEN NAME<br>Elizabeth Bubenik   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) Ill yes, give war or dates of service<br>no  |                  | 16. SOCIAL SECURITY NO.<br>216 03 48100   |                              | 17. INFORMANT<br>Records: BCH-4940 Eastern Avenue 21224                                       |   |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                  | CAUSE OF DEATH<br>Cardio-respiratory arrest<br>Acute myocardial infarction  |                              |   |   |
| 19. DATE OF OPERATION<br>0   |                  | 20. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                              | 20A. AUTOPSY? (Yes or No)<br>No   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                              | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |   |
| 21D. TIME OF INJURY (Approx.)<br>(Month) (Day) (Year) (Hour)   |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>  |                              | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) (this hospital) attended the deceased from 10/27/69 to 10/27/69 that (I) (we) last saw the deceased alive on 10/27/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                  |   |                              |   |   |
| 23A. SIGNATURE<br>J. Torre   |                  | 23B. DATE SIGNED<br>10/28/1969  |                              | 23C. PHYSICIAN'S NAME (Type)<br>JOSE TORRES M.D.  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial   |                  | 24B. DATE<br>10-31-69   |                              | 24C. NAME of CEMETERY or CREMATORY<br>Holy Redeemer Cemetery                                  |   |
| 24D. LOCATION<br>Baltimore, Maryland   |                  | 24E. LOCATION (City, town, or county) (State)<br>Baltimore, Maryland  |                              |   |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br>OCT 30 1969   |                  | 25B. NAME OF REGISTRAR<br>Robert E. Taylor, M.D.  |                              | 25C. FUNERAL DIRECTOR<br>1211 Chesaco Avenue  |   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| T-656  |                  | BALTIMORE CITY HEALTH DEPARTMENT  |                              | REG. NO. 69 10687   |   |
|--|------------------|---|------------------------------|---|---|
| 69 10687   |                  | CERTIFICATE OF DEATH  |                              | 69 10687  |   |
| BIRTH NO.  |                  | 1. NAME OF DECEASED<br>(Type or Print) HARRY R TURNER, SR.  |                              | 2. DATE AND HOUR OF DEATH<br>10/25/69 8:15 P M.   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE MD. B. COUNTY BALTO CO                                    |                              | 2505  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>ST AGNES HOSPITAL<br>WILKENS & CATON AVES.-BALTO., MD.  |                  | C. CITY OR TOWN MARYLAND  |                              | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
|  |                  | E. STREET AND NUMBER<br>3711 ST MARGARET ST @L 21225  |                              |   |   |
| 5. SEX<br>MALE   | 6. RACE<br>WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>04/13/91 | 9. AGE (In years last birthday)<br>78   | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>MACHINIST   |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>B & O RAILROAD   |                              | 11. BIRTHPLACE (State or foreign country)<br>MARYLAND   |   |
| 12. CITIZEN OF WHAT COUNTRY?<br>U S A  |                  | 13. FATHER'S NAME<br>PHILLIP TURNER   |                              | 14. MOTHER'S MAIDEN NAME<br>SARA (MATTHEWS)   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO   |                  | 16. SOCIAL SECURITY NO.<br>705 07 8734  |                              | 17. INFORMANT<br>WILKENS & CATON AVES. BALTO., MD.  |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>412.4 I<br>Pneumonia   |                  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>Arteriosclerotic Cardio-Vascular Disease   |                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>II   |                  | (B) DUE TO, OR AS A CONSEQUENCE OF:<br>C  |                              |   |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |                  |   |                              |   |   |
| 19A. DATE OF OPERATION<br>10   |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                              | 20A. AUTOPSY? (Yes or No)<br>NO   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                              | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |   |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                              | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (X) (this hospital) attended the deceased from 9/12/1969 to 10/25/1969 that (X) (we) last saw the deceased alive on 10/25/1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death. |                  |   |                              |   |   |
| 23A. SIGNATURE<br>Ruben V. Luna MD   |                  | 23B. DATE SIGNED<br>10/25/69  |                              | 23C. PHYSICIAN'S NAME (Type)<br>RUBEN LUNA M.D.   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial   |                  | 24B. DATE<br>10-29-69   |                              | 24C. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Memorial Park                               |   |
| 24D. LOCATION<br>Dorsey Howard Maryland  |                  | 25A. DATE REC'D BY HEALTH DEPT.<br>OCT 30 1969  |                              | 25B. NAME OF REGISTRAR<br>Howard H. Hubbard   |   |
| 25C. FUNERAL DIRECTOR<br>Howard H. Hubbard   |                  | 25D. ADDRESS<br>4107 Wilkens Ave. 21229   |                              |   |   |





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                              |  |                                      |  |  |
|---|------------------------------|--|--------------------------------------|--|--|
| <div style="display: flex; justify-content: space-between;"> <span>W-420</span> <span>69 10688</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> <div style="text-align: right;">             REG. NO. <span style="font-size: 1.2em;">69 10688</span> </div>   |                              |  |                                      |  |  |
| BIRTH NO. _____   |                              | 1. NAME OF DECEASED<br>(Type or Print) <b>JAMES FRANCIS WALLACE, SR.</b>   |                                      | 2. DATE AND HOUR OF DEATH<br><b>October 27, 1969</b> M.                                  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><br><div style="font-size: 1.5em; margin-left: 20px;">00</div> <b>2357 Washington Blvd.<br/>Baltimore, Maryland 21230</b>  |                              | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY _____<br>C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>2357 Washington Blvd.</b> |                                      |  |  |
| 5. SEX<br><b>Male</b>   | 6. RACE<br><b>White</b>      | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>2-15-1892</b> | 9. AGE (In years lost birthday)<br><b>77</b>   | If Under 1 Yr. Months: _____ Days: _____<br>If Under 24 Hrs. Hours: _____ Min. _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Conductor</b>   |                              | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Baltimore Transit Co.</b>  |                                      | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                             |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                              | 13. FATHER'S NAME<br><b>James Francis Wallace</b>  |                                      | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                              | 16. SOCIAL SECURITY NO.<br><b>213-10-1116</b>  |                                      | 17. INFORMANT<br><b>Mrs. Theresa Wallace, 2357 Washington Blvd.</b> ADDRESS <b>21230</b> |  |
| 18. <b>I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)<br><br><b>CAUSE OF DEATH</b><br>(A) IMMEDIATE CAUSE <i>Cancer metastasis</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) _____<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) _____<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><br><i>8 months</i>  |                                      |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><i>None</i>   |                              |  |                                      |  |  |
| 19A. DATE OF OPERATION<br><i>10/18/69</i>   |                              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Trans y neck @ Trans y colon</i>  |                                      | 20A. AUTOPSY? (Yes or No)<br><b>No</b>   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |                              | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                                      | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                 |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)   |                              | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                                      | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>John</i> <b>1968</b> to <i>10/25</i> <b>1969</b> , that (I) (we) lost saw the deceased alive on <i>10/25</i> <b>1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <del>did</del> (did not) view the body after death.   |                              |  |                                      |  |  |
| 23A. SIGNATURE<br><br>  |                              |  |                                      | 23B. DATE SIGNED<br><b>10/28/69</b>  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Dr. Elliott Fishel</b>   |                              | 23D. ADDRESS<br><b>Eutaw &amp; Pratt Streets, Balto., Md.</b>  |                                      |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 24B. DATE<br><b>10-30-69</b> | 24C. NAME of CEMETERY or CREMATORY<br><b>Meadowridge Cemetery</b>  |                                      | 24D. LOCATION (City, town, or county) (State)<br><b>Washington Blvd. Howard Co., Md.</b> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 30 1969</b>   |                              | 25B. NAME OF REGISTRAR<br><i>John</i>  |                                      | 25C. FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b> ADDRESS       |  |

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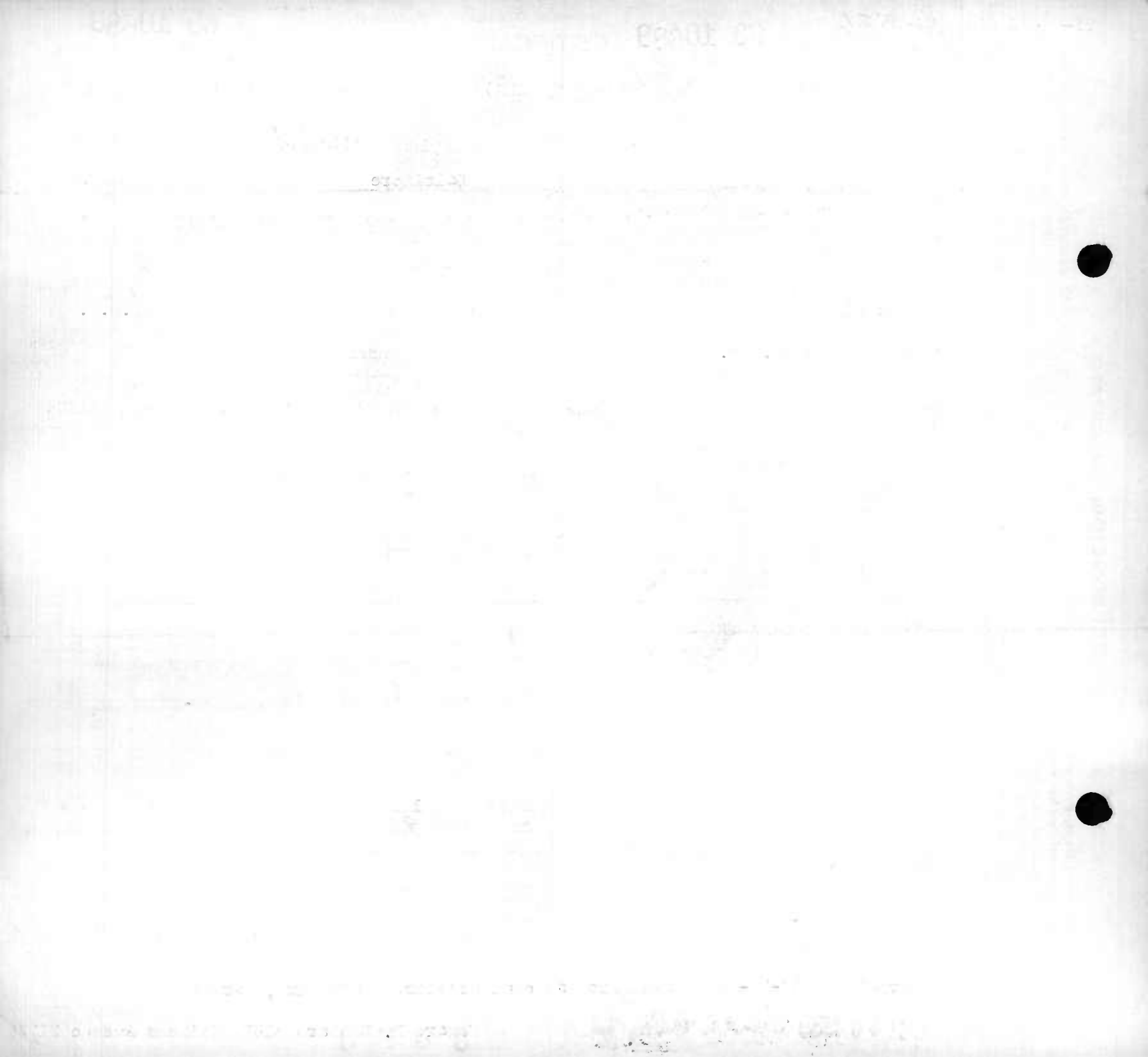
20 of 2

21 of 2

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

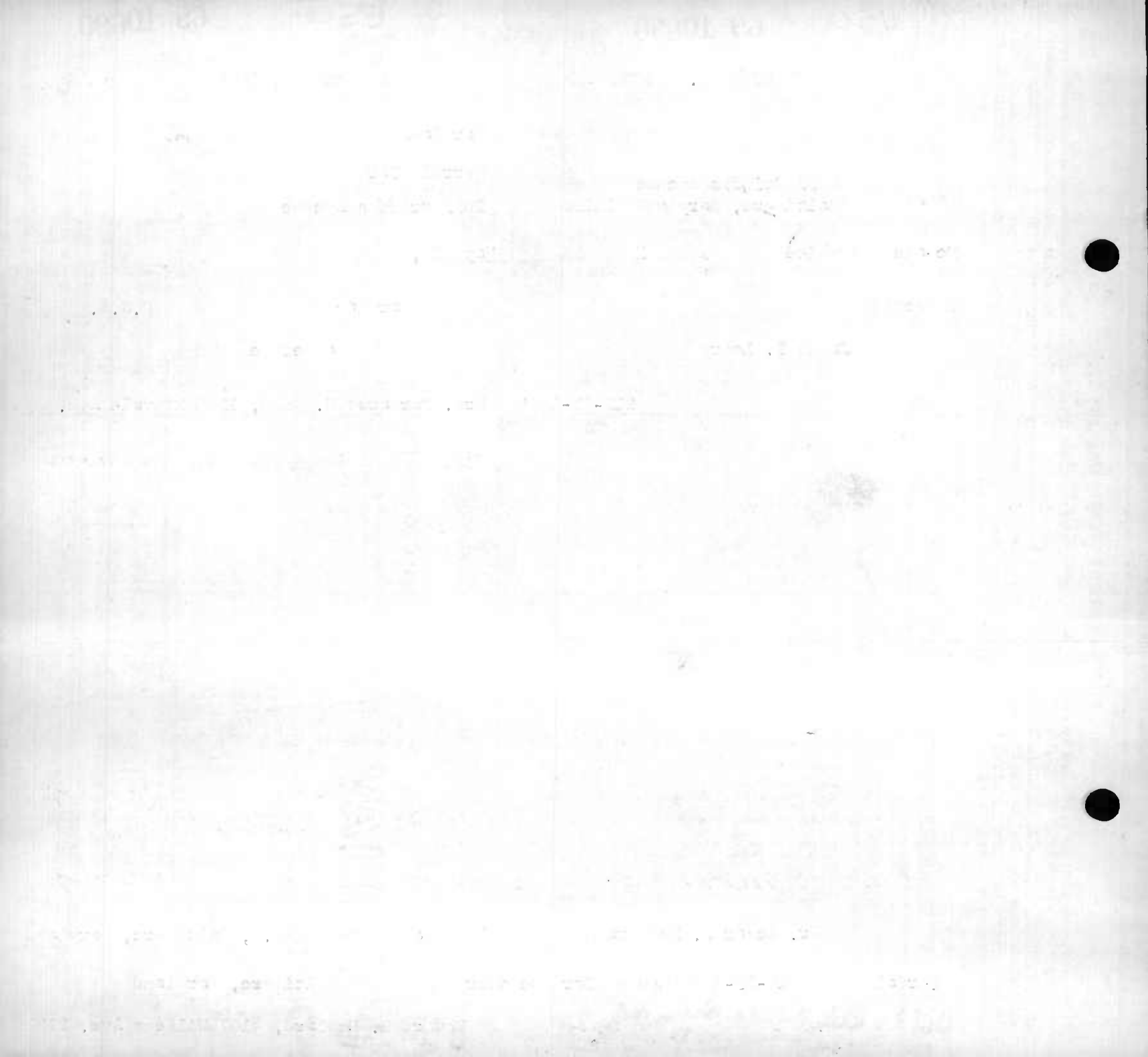
|  |                         |  |   |  |  |
|--|-------------------------|--|---|--|--|
| B-535  |                         | BALTIMORE CITY HEALTH DEPARTMENT   |   | 69 10689   |  |
| BIRTH NO. 69-19246   |                         | CERTIFICATE OF DEATH   |   | REG. NO. 69 10689  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>BINDEMAN, LORRY M. (LORI)</u>  |                         |  | 2. DATE AND HOUR OF DEATH<br><u>10-26-69</u> <u>1:20</u> P.M.   |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital or institution, give street address or location)<br><u>BALTIMORE CITY HOSPITALS</u><br><u>4940 Eastern Avenue Baltimore, Maryland 21224</u>   |                         |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>101 Cherry Dell Road 21228</u> |  |  |
| 5. SEX<br><u>Female</u>  | 6. RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>10-17-69</u>   | 9. AGE (In years last birthday)<br><u>9</u>                              | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Child</u>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>             |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |                         | 13. FATHER'S NAME<br><u>Bernard Bindeman, Jr.</u>  |   | 14. MOTHER'S MAIDEN NAME<br><u>June Glanzer</u>                          |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>  |                         | 16. SOCIAL SECURITY NO.<br><u>None</u>   |   | 17. INFORMANT<br><u>BCH: Records Baltimore, Maryland 21224</u>           |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><u>HEMORRAGE</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br><u>MULTIPLE</u><br><u>RENAL ATRESIA</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br><u>-</u>      |                         |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |
| 19. DATE OF OPERATION<br><u>10-29-69</u>   |                         |  | 20. AUTOPSY? (Yes or No)<br><u>No</u>   |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                         |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                         |  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |  |  |
| 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                         |  | 21F. HOW DID INJURY OCCUR?  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10-22</u> 19 <u>69</u> to <u>10-26</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>10-26</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |  |   |  |  |
| 23A. SIGNATURE<br><u>M. Alvarez</u>  |                         |  | 23B. DATE SIGNED<br><u>10-26-69</u>   |  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>M. ALVAREZ</u>  |                         |  | 23D. ADDRESS<br><u>4940 Eastern Avenue Baltimore, Maryland</u>  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                         | 24B. DATE<br><u>10-29-69</u>   |   | 24C. NAME of CEMETERY or CREMATORY<br><u>Baltimore National Cemetery</u> |  |
| 24D. LOCATION<br><u>Baltimore, Maryland</u>  |                         | 24E. DATE REC'D BY HEALTH DEPT.<br><u>OCT 30 1969</u>  |   |  |  |
| 24F. NAME OF REGISTRAR<br><u>Robert E. Taylor</u>  |                         | 24G. FUNERAL DIRECTOR<br><u>Howard H. Hubbard</u>  |   |  |  |
| 24H. ADDRESS<br><u>4107 Wilkens Avenue 21229</u>   |                         | 24I. ADDRESS   |   |  |  |



# FUNERAL DIRECTOR: IMPORTANT

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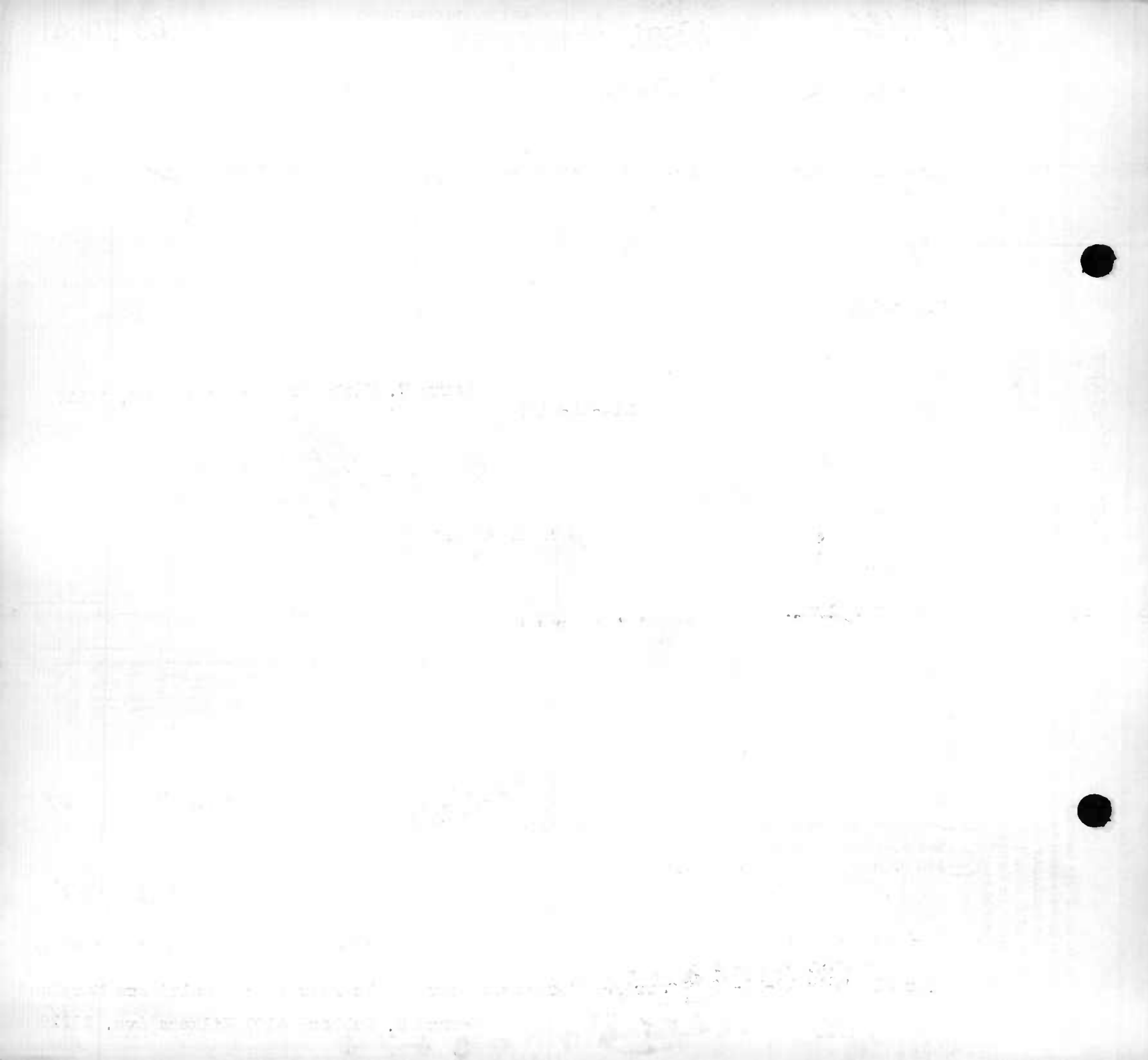
| C-450   |                  |   |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | REG. NO. 69 10690  |  |
|---|------------------|---|--|--|--|--|--|
| 69 10690  |                  |   |  | CERTIFICATE OF DEATH   |  |  |  |
| BIRTH NO.   |                  |   |  | 1. NAME OF DECEASED<br>(Type or Print)   |  | 2. DATE AND HOUR OF DEATH  |  |
|   |                  |   |  | MARY A. COOLAHAN   |  | October 24, 1969 4:30p. M.   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                  |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)  |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><br>2055 Griffis Avenue<br>Baltimore, Maryland 21230  |                  |   |  | A. STATE<br>Maryland   |  | B. COUNTY  |  |
|   |                  |   |  | C. CITY OR TOWN<br>Morrell Park  |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| E. STREET AND NUMBER<br>2055 Griffis Avenue   |                  |   |  |  |  |  |  |
| 5. SEX<br>Female  | 6. RACE<br>White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>May 10, 1901   |  | 9. AGE (In years lost birthday)<br>68  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife  |                  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br>Maryland  |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 13. FATHER'S NAME<br>James P. Leary   |                  |   |  | 14. MOTHER'S MAIDEN NAME<br>Catherine Convey   |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces?<br>(Yes, no or unknown) (If yes, give war or dates of service)<br>No   |                  | 16. SOCIAL SECURITY NO.<br>215-22-1886  |  | 17. INFORMANT<br>Mrs. Margaret C. Koch, 1300 Midvale Ave.  |  |  |  |
|   |                  |   |  | ADDRESS<br>21228   |  |  |  |
| 18. CAUSE OF DEATH  |                  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                  |   |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>Essential Hypertension years-<br>(B) unknown<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                  |   |  |  |  |  |  |
| 19A. DATE OF OPERATION  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?               |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)  |  |  |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)   |                  | 21E. INJURY OCCURRED<br>While At <input type="checkbox"/> Not While <input type="checkbox"/><br>Work At Work <input type="checkbox"/>                       |  | 21F. HOW DID INJURY OCCUR?   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 8-29-1967 to 2-1-1969, that (I) (we) last saw the deceased alive on 2-1-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. Medical Examiner's            |                  |   |  |  |  |  |  |
| 23A. SIGNATURE<br>Cesar J. Pellerano  |                  |   |  | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>                  |  | 23B. DATE SIGNED<br>10/27/69   |  |
| 23C. PHYSICIAN'S NAME (Type)<br>Dr. Cesar J. Pellerano  |                  |   |  | 23D. ADDRESS<br>2436 Washington Blvd., Baltimore, Maryland   |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |                  | 24B. DATE<br>10-28-1969   |  | 24C. NAME of CEMETERY or CREMATORY<br>Loudon Park Cemetery   |  | 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Maryland               |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>OCT 30 1969  |                  | 25B. NAME OF REGISTRAR<br>Robert E. Taylor, M.D.  |  | 25C. FUNERAL DIRECTOR<br>Howard M. Hubbard   |  | ADDRESS<br>4107 Wilkens Ave. 21229   |  |



# FUNERAL DIRECTOR: IMPORTANT

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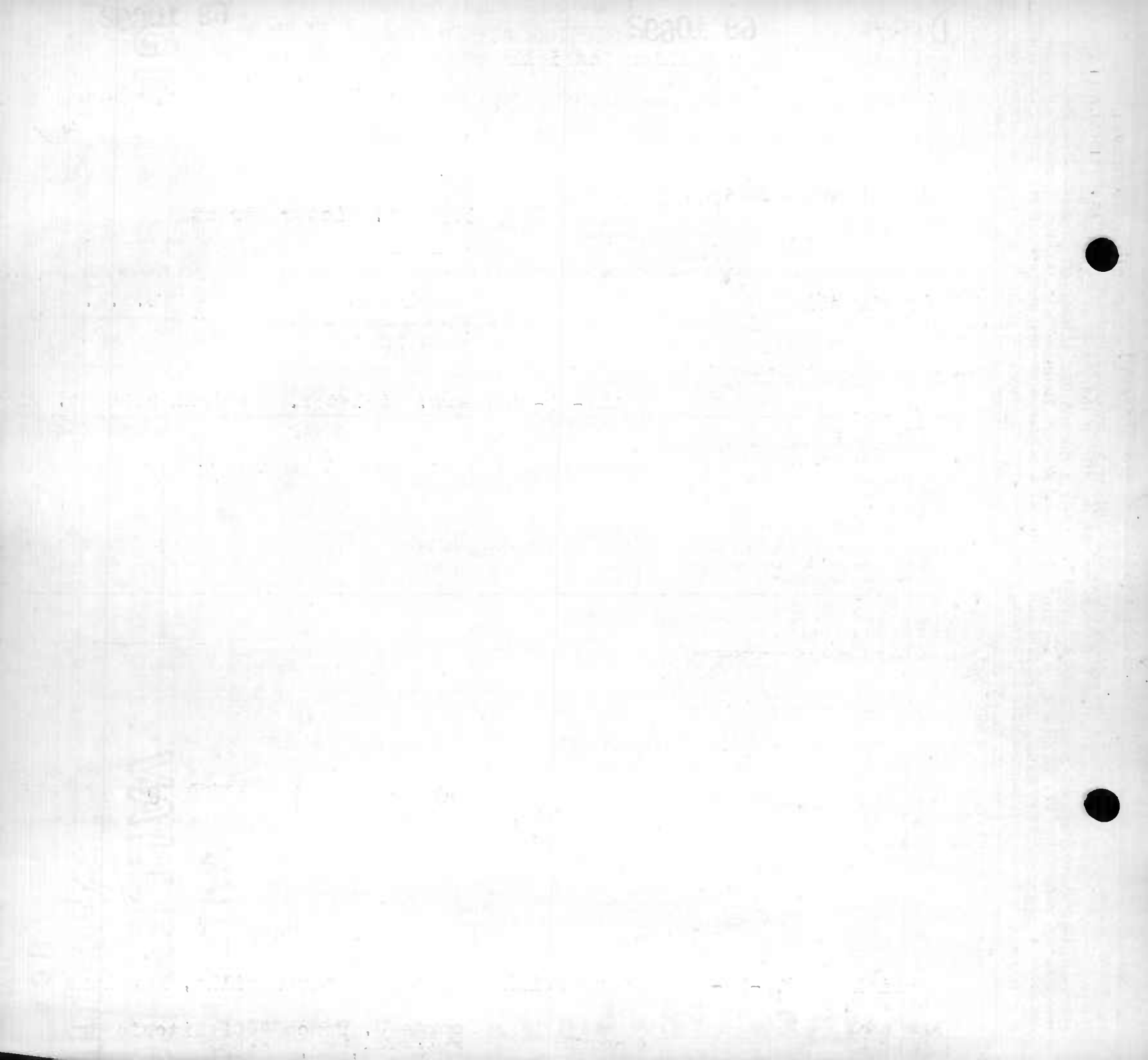
| BALTIMORE CITY HEALTH DEPARTMENT   |                     |   |                                    | REG. NO.  | 69 10691   |
|--|---------------------|---|------------------------------------|---|--|
| <b>BIRTH NO.</b><br><b>1. NAME OF DECEASED</b><br>(Type or Print)<br>MARGARET L. FLETCHER  |                     | <b>2. DATE AND HOUR OF DEATH</b><br>10-27-69 8 <sup>55</sup> P.M.   |                                    |   |  |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>SOUTH BALTIMORE GENERAL HOSPITAL<br>43   |                     | <b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution residence before admission)<br>A. STATE: md B. COUNTY: BALTO. CO. 5300<br><b>C. CITY OR TOWN</b> : Baltimore<br><b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br><b>E. STREET AND NUMBER</b> : 2402 Alma Road |                                    |   |  |
| <b>5. SEX</b><br>F   | <b>6. RACE</b><br>W | <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>   | <b>8. DATE OF BIRTH</b><br>6-29-13 | <b>9. AGE</b> (In years last birthday)<br>56                                    | <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br>Housewife |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br>Housewife  |                     | <b>10B. KIND OF BUSINESS OR INDUSTRY</b>  |                                    | <b>11. BIRTHPLACE</b> (State or foreign country)<br>Maryland                    | <b>12. CITIZEN OF WHAT COUNTRY?</b><br>USA   |
| <b>13. FATHER'S NAME</b><br>Frederick Kemp   |                     | <b>14. MOTHER'S MAIDEN NAME</b><br>Elsie Teat   |                                    |   |  |
| <b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)<br>No  |                     | <b>16. SOCIAL SECURITY NO.</b><br>214-01-6167   |                                    | <b>17. INFORMANT</b><br>Harry V. Fletcher<br>Hospital Record                    |  |
| <b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>410.9 I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                     | <b>CAUSE OF DEATH</b><br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>Machine Acute Myocardial Infarction -<br>(B) A.S.C.V.D. -<br>(C)  |                                    |   |  |
| <b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                     |   |                                    |   |  |
| <b>19A. DATE OF OPERATION</b><br>10/27/69  |                     | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>   |                                    | <b>20A. AUTOPSY?</b> (Yes or No)  |  |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner)   |                     | <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                                    | <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) |  |
| <b>21D. TIME OF INJURY</b> (APPROX.) (Month) (Day) (Year) (Hour)   |                     | <b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                                    | <b>21F. HOW DID INJURY OCCUR?</b>   |  |
| <b>22. I certify that (I) (this hospital) attended the deceased from</b> 10/26 1969 <b>to</b> 10/27 1969 <b>that (I) (we) last saw the deceased alive on</b> 10/27 1969 <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>  |                     |   |                                    |   |  |
| <b>23A. SIGNATURE</b><br>E.M. RAMOS M.D.   |                     |   |                                    | <b>23B. DATE SIGNED</b><br>10/27/69   |  |
| <b>23C. PHYSICIAN'S NAME</b> (Type)<br>E.M. RAMOS M.D.   |                     | <b>23D. ADDRESS</b><br>3927 ANNAPOLIS RD. BALT. MARYLAND  |                                    |   |  |
| <b>24A. BURIAL CREMATION, REMOVAL (Specify)</b><br>Burial  |                     | <b>24B. DATE</b><br>10-31-69  |                                    | <b>24C. NAME OF CEMETERY OR CREMATORY</b><br>Garrison Forest Cemetery           |  |
| <b>24D. LOCATION</b> (City, town, or county) (State)<br>Reisterstown Baltimore Maryland  |                     | <b>25A. DATE REC'D BY HEALTH DEPT.</b><br>OCT 30 1969   |                                    |   |  |
| <b>25B. NAME OF REGISTRAR</b><br>Robert J. ...   |                     | <b>25C. FUNERAL DIRECTOR</b><br>Howard H. Hubbard 4107 Wilkens Ave. 21229   |                                    |   |  |





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| D-240  |  | 69 10692   |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. 69 10692   |  |
| BIRTH NO.  |  |  |  | 1. NAME OF DECEASED<br>(Type or Print) George Allen Dashiell  |  |   |  |
| 2. DATE AND HOUR OF DEATH<br>10/27/69 3 30 P.M.  |  |  |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>Johns Hopkins Hospital   |  |  |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |  |   |  |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE MARYLAND<br>B. COUNTY  |  |  |  | C. CITY OR TOWN<br>BALTIMORE  |  |   |  |
| D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  | E. STREET AND NUMBER<br>3736 St. Victor Street  |  |   |  |
| 5. SEX<br>M  |  | 6. RACE<br>W   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>12-15-08  |  |
| 9. AGE (In years last birthday)<br>59  |  | If Under 1 Yr. Months: Days: Hours: Min.   |  | 11. BIRTHPLACE (State or foreign country)<br>Maryland   |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Construction  |  |  |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 13. FATHER'S NAME<br>GEORGE  |  |  |  | 14. MOTHER'S MAIDEN NAME<br>MARY  |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No   |  |  |  | 16. SOCIAL SECURITY NO.<br>220-03-4299  |  |   |  |
| 17. INFORMANT<br>Mrs. Violet T. Dashiell   |  |  |  | ADDRESS<br>3736 St. Victor Street   |  |   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>4.30.9 I<br>SUBARACHNOID HEMORRHAGE ~ 36 hours   |  |  |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C)   |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |  |  |   |  |   |  |
| 19A. DATE OF OPERATION   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?    |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from 4:15 AM 10/26 1969 to 3:30 PM 10/27 1969, that (I) (we) last saw the deceased alive on 3:30 PM 10/27 1969 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 23A. SIGNATURE<br>Leroy M. Parker M.D.   |  |  |  | 23B. DATE SIGNED<br>10/27/69  |  | 23C. PHYSICIAN'S NAME (Type)<br>L. M. PARKER                            |  |
| 23D. ADDRESS<br>Johns Hopkins Hospital   |  |  |  | 23E. NAME OF REGISTRAR  |  | 23F. FUNERAL DIRECTOR<br>George J. Gonce                                |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial   |  | 24B. DATE<br>10-30-69  |  | 24C. NAME OF CEMETERY or CREMATORY<br>Stevensville Cemetery   |  | 24D. LOCATION (City, town, or county) (State)<br>Stevensville, Maryland |  |
| 25A. DATE REC'D BY HEALTH DEPT.  |  | 25B. NAME OF REGISTRAR   |  | 25C. FUNERAL DIRECTOR   |  | ADDRESS<br>4001 Ritchie Hgy<br>Baltimore, Md. 21225                     |  |



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 10693

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPH ROKOSKY

2. DATE  
OF  
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 834 N. Chester Street (DOA)

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

October 28, 1969

5:40 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)  
A. STATE B. COUNTY

Maryland

704

6. SEX

Male

7. RACE

White

B. MARRIED ☐NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

July 14, 1899

10. AGE (In years  
lost birthday)

70

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

834 N. Chester Street

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Frank Rokosky

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Clerk

14B. KIND OF BUSINESS OR INDUSTRY

Balto. City

15. MOTHER'S MAIDEN NAME

Anna Poledna

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

214-18-6988

18. INFORMANT

Francis Rokosky 4818 Clayburg Ave. Balto. Md.

ADDRESS

19. 412.4  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

Arteriosclerotic Cardiovascular Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/29/69

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

10-31-69

24C. NAME of CEMETERY or CREMATORY

Holy Redeemer Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

OCT 31 1969

25B. NAME OF REGISTRAR

Robert E. Reddy, M.D.

25C. FUNERAL DIRECTOR

Philip C. Grach

ADDRESS

1211 Ches

22 1000

12 10 32

PO 210

7.514

MILITARY

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                      |  |   |
|--|----------------------|--|---|
| Baltimore City Health Department   |                      | REG. NO. <b>69 10694</b>   |   |
| F-620  |                      | 69 10694   |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>ELIZABETH M. FRIES</b>   |                      | 2. DATE AND HOUR OF DEATH<br><b>10/26/69 6<sup>10</sup> P.M.</b>   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>3421 Elliott St.<br/>Baltimore, 21224, Md.</b>   |                      | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>2609</b><br>C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>3421 Elliott St. # 21224.</b> |   |
| 5. SEX <b>Female</b>   | 6. RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <b>Oct. 29, 1889</b>     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>   |                      | 10B. KIND OF BUSINESS OR INDUSTRY <b>House Work</b>  | 9. AGE (In years last birthday) <b>79</b> |
| 11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>  |                      | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |   |
| 13. FATHER'S NAME <b>Ambrose Hessler</b>   |                      | 14. MOTHER'S MAIDEN NAME <b>Anna Haseni</b>  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>   |                      | 16. SOCIAL SECURITY NO.  |   |
| 17. INFORMANT <b>Frank P. Fries, Sr.</b>   |                      | ADDRESS <b>2256 Graythorn Rd. Ba. Co. Md.</b>  |   |
| 18. <b>45891</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>Pulmonary Embolism</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Surgical Venous Stenosis</b><br><b>(H) Pleurisy 1 WK Ag</b> |                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>&lt; 24 Hrs.</b><br><b>&gt; 1 WK.</b>   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                      |  |   |
| 19A. DATE OF OPERATION <b>0</b>  |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |
| 20A. AUTOPSY? (Yes or No)  |                      | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |   |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                      | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |   |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                      | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10/19 1969</b> to <b>10/26 1969</b> , that (I) (we) last saw the deceased alive on <b>10/19 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                      |  |   |
| 23A. SIGNATURE <b>Raymond D. Baner</b>   |                      | 23B. DATE SIGNED <b>10/26/69</b>   |   |
| 23C. PHYSICIAN'S NAME (Type) <b>Raymond D. BANER</b>   |                      | 23D. ADDRESS <b>Walters &amp; Peni Heights Ave.</b>  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>   |                      | 24B. DATE <b>10-30-69.</b>   |   |
| 24C. NAME OF CEMETERY or CREMATORY <b>Saored Heart Cemetery</b>  |                      | 24D. LOCATION (City, town, or county) (State) <b>7401 German Hill Rd., Ba. Co., Md.</b>  |   |
| 25A. DATE REC'D BY HEALTH DEPT. <b>OCT 31 1969</b>   |                      | 25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>   |   |
| 25C. FUNERAL DIRECTOR <b>Charles S. Zoller</b>   |                      | ADDRESS <b>901 S. Conkling St. Balto., 21224, Md.</b>  |   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |   |  |
|--|--|---|--|
| <div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. <b>D-552</b></span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> <span>REG. NO. <b>69 10695</b></span> </div>  |  |   |  |
| <b>1. NAME OF DECEASED</b><br>(Type or Print) <span style="float: right;"><b>PAUL DEMIANCHIK</b></span>  |  | <b>2. DATE AND HOUR OF DEATH</b><br><div style="display: flex; justify-content: space-between;"> <span><b>October 26, 1969</b></span> <span><b>10:40 A.M.</b></span> </div>   |  |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><br><div style="display: flex; justify-content: space-between;"> <div> <b>FULL NAME OF HOSPITAL OR INSTITUTION</b><br/> <b>00</b> </div> <div> <b>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</b><br/> <b>3320 Fait Ave.</b><br/> <b>Baltimore, 21224, Md.</b> </div> </div>                       |  | <b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)<br><div style="display: flex; justify-content: space-between;"> <div> <b>A. STATE</b><br/> <b>Md.</b> </div> <div> <b>B. COUNTY</b><br/> <b>2611</b> </div> </div> |  |
| <b>5. SEX</b><br><div style="display: flex; justify-content: space-between;"> <span><b>Male</b></span> <span><b>White</b></span> </div>  |  | <b>6. RACE</b><br><div style="display: flex; justify-content: space-between;"> <span><b>White</b></span> </div>   |  |
| <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>  |  | <b>8. DATE OF BIRTH</b><br><b>June 4, 1915</b>  |  |
| <b>9. AGE</b> (In years last birthday)<br><b>54</b>  |  | <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Administrator</b>   |  |
| <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>Monessen, Pa.</b>   |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>U.S.A.</b>  |  |
| <b>13. FATHER'S NAME</b><br><b>Hnat Demianchik</b>   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Christina Dzubin</b>  |  |
| <b>15. Was Deceased Ever in U. S. Armed Forces?</b><br>(Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes W.W.II</b>  |  | <b>16. SOCIAL SECURITY NO.</b><br><b>215-05-1370</b>  |  |
| <b>17. INFORMANT</b><br><b>Matilda Demianchik :</b>  |  | <b>ADDRESS</b><br><b>Same.</b>  |  |
| <b>18. CAUSE OF DEATH</b><br><b>410.9 I</b><br><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. |  | <b>(A) IMMEDIATE CAUSE</b><br><b>Coronary Thrombosis</b><br><b>DUE TO, OR AS A CONSEQUENCE OF:</b><br><b>(B) Arteriosclerotic CV Disease</b><br><b>DUE TO, OR AS A CONSEQUENCE OF:</b><br><b>(C) _____</b>  |  |
| <b>19. DATE OF OPERATION</b><br><b>0</b>   |  | <b>20. AUTOPSY? (Yes or No)</b><br><b>NO</b>  |  |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>  |  | <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  |
| <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)  |  | <b>21D. TIME OF INJURY (APPROX.)</b>  |  |
| <b>21E. INJURY OCCURRED</b><br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | <b>21F. HOW DID INJURY OCCUR?</b>   |  |
| <b>22. I certify that (I) (this hospital) attended the deceased from</b> <b>Dec. 3, 1965</b> <b>to Dec 26, 1969.</b><br><b>that (I) (we) last saw the deceased alive on</b> <b>Oct. 26, 1969</b> <b>and that in (my) (our) opinion death occurred on the date</b><br><b>and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</b>                   |  |   |  |
| <b>23A. SIGNATURE</b><br><b>Jason H. Gaskel</b>  |  | <b>23B. DATE SIGNED</b><br><b>10-27-69</b>  |  |
| <b>23C. PHYSICIAN'S NAME (Type)</b><br><b>Jason H. Gaskel</b>  |  | <b>23D. ADDRESS</b><br><b>637 S. Conkling St., Balto., 21224, Md.</b>   |  |
| <b>24A. BURIAL CREMATION, REMOVAL (Specify)</b><br><b>Burial</b>   |  | <b>24B. DATE</b><br><b>10-30-69.</b>  |  |
| <b>24C. NAME of CEMETERY or CREMATORY</b><br><b>St. Stanislaus Cem.</b>  |  | <b>24D. LOCATION</b> (City, town, or county) (State)<br><b>6515 Boston Ave., Balto., Md.</b>  |  |
| <b>25A. DATE REC'D BY HEALTH DEPT.</b><br><b>OCT 31 1969</b>   |  | <b>25B. NAME OF REGISTRAR</b><br><b>Charles J. Seiler</b>   |  |
| <b>25C. FUNERAL DIRECTOR</b><br><b>Charles J. Seiler</b>   |  | <b>ADDRESS</b><br><b>901 S. Conkling St. Balto., 21224, Md.</b>   |  |

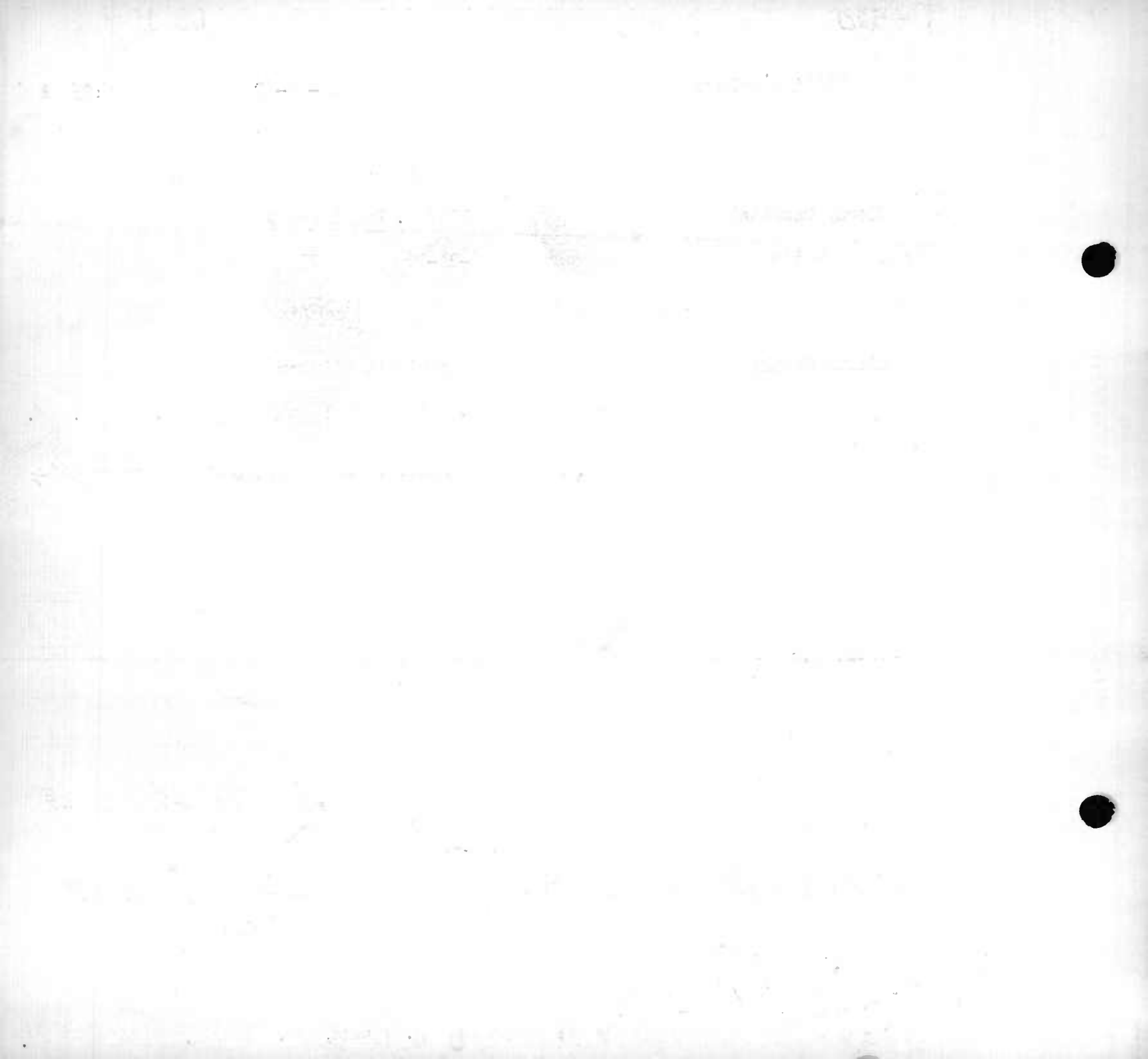




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| J-520  |  |   |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | 69 10696                                   |  |
|--|--|---|--|---|--|--|--|
| 69 10696   |  |   |  | CERTIFICATE OF DEATH  |  | REG. NO.                                   |  |
| 1. NAME OF DECEASED<br>(Type as Print) <u>William Jahnke</u>   |  |   |  | 2. DATE AND HOUR OF DEATH<br><u>10-29-69</u> <u>5:25 A.M.</u>   |  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>37 Mercy Hospital</u>  |  |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>Md</u><br>B. COUNTY <u>2610</u>                        |  |  |  |
| 5. SEX<br><u>Male</u>  |  | 6. RACE<br><u>White</u>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>6-24-96</u>         |  |
| 9. AGE (In years last birthday)<br><u>73</u>   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Sail Maker</u> |  | 11. BIRTHPLACE (State or foreign country)<br><u>Baltimore, Maryland</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u> |  |
| 13. FATHER'S NAME<br><u>Adolph Jahnke</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Henrietta Blisker</u>  |  |  |  |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>  |  | 16. SOCIAL SECURITY NO.<br><u>212-16-4062</u>   |  | 17. INFORMANT<br><u>Mrs. Wilhelmina Jahnke 3328 E. Balto. St.</u>   |  |  |  |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><u>Carcinoma of Lung</u><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>II</u><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br>19A. DATE OF OPERATION <u>0</u><br>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>20A. AUTOPSY? (Yes or No) <u>NO</u><br>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u><br>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)<br>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/><br>21F. HOW DID INJURY OCCUR?<br>22. I certify that (I) (this hospital) attended the deceased from <u>10-18</u> 19 <u>69</u> to <u>10-29</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>10-29</u> 19 <u>69</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.<br>23A. SIGNATURE <u>Michael P. Buchness M.D.</u><br>23B. DATE SIGNED <u>10-29-69</u><br>23C. PHYSICIAN'S NAME (Type)<br>23D. ADDRESS <u>Mercy Hospital</u><br>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u><br>24B. DATE <u>11/1/69</u><br>24C. NAME of CEMETERY or CREMATORY <u>Schwartz Cemetery</u><br>24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u><br>25A. DATE REC'D BY HEALTH DEPT. <u>OCT 31 1969</u><br>25B. NAME OF REGISTRAR <u>John A. Moran, Inc.</u><br>25C. FUNERAL DIRECTOR ADDRESS <u>3000 E. Baltimore St.</u> |  |   |  |   |  |  |  |



1

69 10697

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 10697

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Frank McKnight

2. DATE OF DEATH Known ☒ Estimated ☐ Month 10 Day 18 Year 69 Hour 9:40 a.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2026 Booth St.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2003

6. SEX male 7. RACE colored 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES ☐ NO ☐

9. DATE OF BIRTH 10. AGE (In years lost birthday) 74 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. E. STREET AND NUMBER 2026 Booth St.

11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? 13. FATHER'S NAME

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 14B. KIND OF BUSINESS OR INDUSTRY 15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 17. SOCIAL SECURITY NO. 18. INFORMANT ADDRESS

19. 412.4 CAUSE OF DEATH Arteriosclerotic cardiovascular disease (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) NO

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 22F. HOW DID INJURY OCCUR?

23. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner DATE SIGNED 10/18/69

24A. BURIAL CREMATION, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETERY or CREMATORY 24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT. 25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR ADDRESS

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

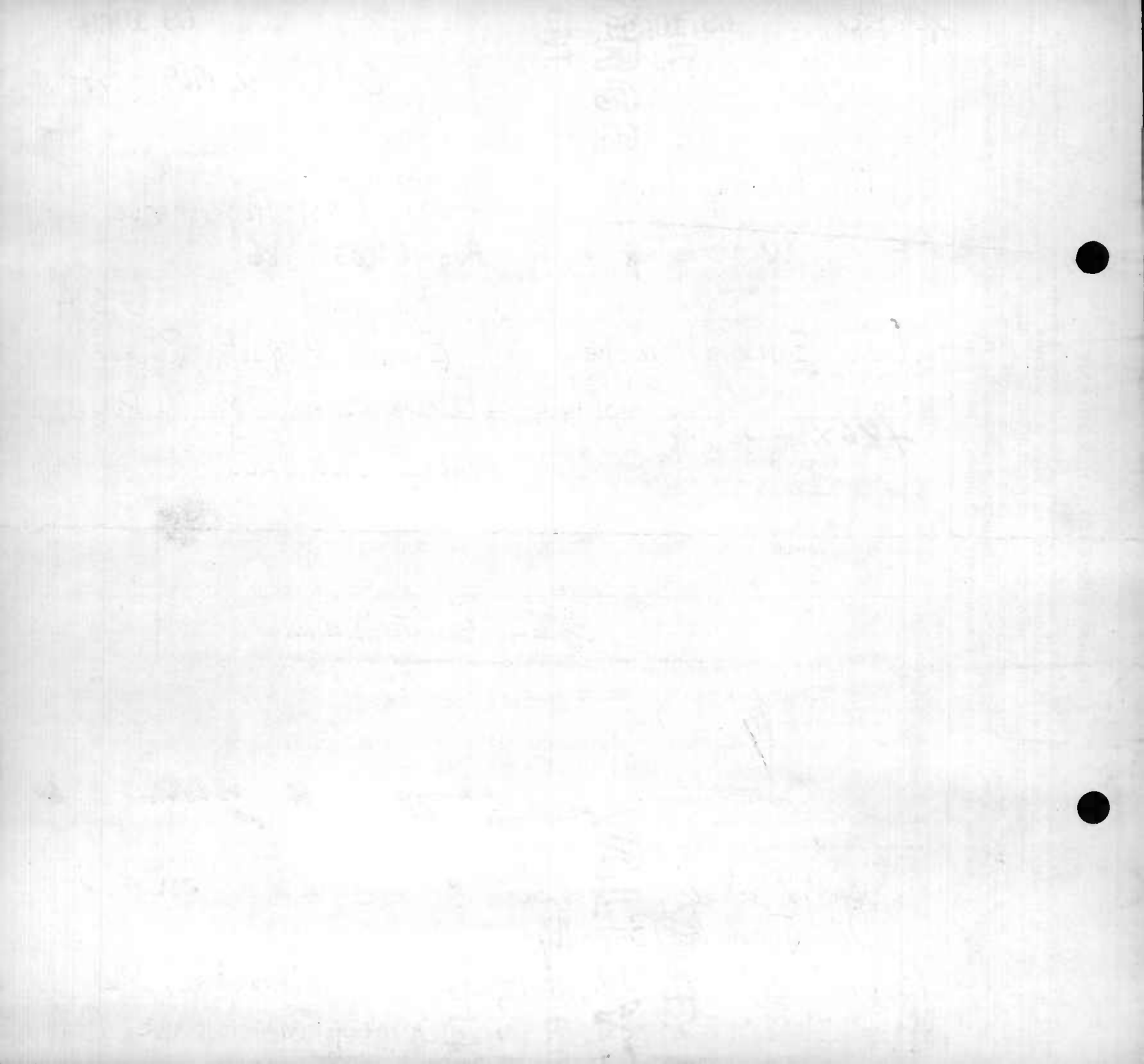
| BALTIMORE CITY HEALTH DEPARTMENT   |  |  |  | REG. NO. <span style="float: right;">69 10698</span>                           |  |
|--|--|--|--|--|--|
| <b>H-520</b><br><b>69 10698</b><br><b>CERTIFICATE OF DEATH</b>   |  | <b>1. NAME OF DECEASED</b><br>(Type or Print) <i>Anna Marie Henze</i>  |  |  |  |
| <b>2. DATE AND HOUR OF DEATH</b><br><i>October 27 1969 10:45 A.</i>  |  | <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  |  |  |  |
| <b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY <i>2755</i>   |  | <b>5. FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location)<br><i>5607 Matfeldt Ave</i>  |  |  |  |
| <b>6. CITY OR TOWN</b><br><i>Baltimore</i>   |  | <b>7. INSIDE CITY LIMITS?</b><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| <b>8. STREET AND NUMBER</b><br><i>5607 Matfeldt Ave</i>  |  | <b>9. SEX</b><br><i>Female</i>   |  |  |  |
| <b>10. RACE</b><br><i>White</i>  |  | <b>11. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> |  | <b>12. DATE OF BIRTH</b><br><i>April 11 1898</i>                               |  |
| <b>13. AGE</b> (In years last birthday)<br><i>71</i>   |  | <b>14. BIRTHPLACE</b> (State or foreign country)<br><i>Germany</i>   |  | <b>15. CITIZEN OF WHAT COUNTRY?</b><br><i>USA</i>                              |  |
| <b>16. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><i>Technician</i>   |  | <b>17. KIND OF BUSINESS OR INDUSTRY</b><br><i>Chemical Research</i>  |  | <b>18. FATHER'S NAME</b><br><i>Emil Siefenbuttel</i>                           |  |
| <b>19. MOTHER'S MAIDEN NAME</b><br><i>Amelia Klaus</i>   |  | <b>20. Was Deceased Ever in U. S. Armed Forces?</b> (If yes, give war or dates of service)<br><i>No</i>  |  | <b>21. SOCIAL SECURITY NO.</b><br><i>216 321638</i>                            |  |
| <b>22. INFORMANT</b><br><i>Fritz W Henze</i>   |  | <b>23. ADDRESS</b><br><i>Same</i>  |  |  |  |
| <b>24. CAUSE OF DEATH</b>  |  |  |  |  |  |
| <b>I</b><br><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b> |  |  |  |  |  |
| <b>25. IMMEDIATE CAUSE</b><br><i>Carcinoma of Gall Bladder</i><br>DUE TO, OR AS A CONSEQUENCE OF:  |  | <b>26. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b><br><i>known</i>  |  |  |  |
| <b>27. DUE TO, OR AS A CONSEQUENCE OF:</b>   |  | <b>28. DUE TO, OR AS A CONSEQUENCE OF:</b>   |  |  |  |
| <b>29. DUE TO, OR AS A CONSEQUENCE OF:</b>   |  | <b>30. DUE TO, OR AS A CONSEQUENCE OF:</b>   |  |  |  |
| <b>MEDICAL CERTIFICATION</b>   |  |  |  |  |  |
| <b>31. DATE OF OPERATION</b><br><i>July 17, 1969</i>   |  | <b>32. CONDITION FOR WHICH OPERATION WAS PERFORMED</b><br><i>Ca of G.B.</i>  |  | <b>33. AUTOPSY?</b> (Yes or No)<br><i>No</i>                                   |  |
| <b>34. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)<br><input type="checkbox"/>  |  | <b>35. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | <b>36. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) |  |
| <b>37. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)<br>(APPROX.)   |  | <b>38. INJURY OCCURRED</b><br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | <b>39. HOW DID INJURY OCCUR?</b>   |  |
| <b>40. I certify that (I) (this hospital) attended the deceased from <i>3-18</i> 19<i>69</i> to <i>10-27</i> 19<i>69</i>, that (I) (we) last saw the deceased alive on <i>10-24</i> 19<i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</b>   |  |  |  |  |  |
| <b>41. SIGNATURE</b><br><i>L. J. Shimaneck M.D.</i>  |  |  |  | <b>42. DATE SIGNED</b><br><i>10-29-69</i>                                      |  |
| <b>43. PHYSICIAN'S NAME</b> (Type)<br><i>L. J. Shimaneck M.D.</i>  |  |  |  | <b>44. ADDRESS</b><br><i>3711 Falls Rd Balto Md 21211</i>                      |  |
| <b>45. BURIAL CREMATION, REMOVAL</b> (Specify)<br><i>Buried</i>  |  | <b>46. DATE</b><br><i>10-30-69</i>   |  | <b>47. NAME OF CEMETERY or CREMATORY</b><br><i>Dulency Valley Mem.</i>         |  |
| <b>48. LOCATION</b> (City, town, or county) (State)<br><i>Cockeysville Balto Md</i>  |  | <b>49. DATE REC'D BY HEALTH DEPT.</b><br><i>OCT 31 1969</i>  |  |  |  |
| <b>50. NAME OF REGISTRAR</b><br><i>John E. Bailey M.D.</i>   |  | <b>51. FUNERAL DIRECTOR</b><br><i>Burgess Funeral Home Balto Md</i>  |  |  |  |
| <b>52. ADDRESS</b><br><i>3711 Falls Rd Balto Md</i>  |  |  |  |  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| K-650  |  | 69 10699  |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. 69 10699   |  |
| BIRTH NO.  |  |   |  | 1. NAME OF DECEASED<br>(Type or Print) <u>Grace E. Krom</u>   |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |   |  | 2. DATE AND HOUR OF DEATH<br><u>October 26 1969</u> <u>12:30 A</u> M.   |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>90 The Wesley Home</u>  |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                      |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>Maryland</u> B. COUNTY <u>2755</u>                     |  | C. CITY OR TOWN<br><u>Baltimore</u>                                     |  |
| 5. SEX<br><u>F</u>   |  | 6. RACE<br><u>W</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>Aug 16 1883</u>                                  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 9. AGE (In years last birthday)<br><u>86</u>  |  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.               |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |   |  |
| 13. FATHER'S NAME<br><u>Wm. Edward Mackey</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Emma Augusta Brown</u>   |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>  |  | 16. SOCIAL SECURITY NO.<br><u>101 14 40034</u>  |  | 17. INFORMANT<br><u>Wesley Home</u>   |  | ADDRESS<br><u>2211 W Rogers Ave.</u>                                    |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><u>486 x 1 250.9</u><br>I (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><u>Epilepsy - Diabetes Mellitus</u> |  |   |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><u>Aspiration pneumonia</u><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____    |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                            |  |
| 19A. DATE OF OPERATION   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><u>No</u>  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?    |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>January</u> 19 <u>68</u> to <u>26 October</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>24 October</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |
| 23A. SIGNATURE<br><u>John A. Barnaby</u>   |  |   |  | 23B. DATE SIGNED<br><u>28 Oct 69</u>  |  | 23C. PHYSICIAN'S NAME (Type)<br><u>Dr John A. Barnaby</u>               |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |  | 24B. DATE<br><u>29 Oct 69</u>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><u>Druid Ridge</u>  |  | 24D. LOCATION (City, town, or county) (State)<br><u>Pikesville, Md.</u> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>OCT 31 1969</u>  |  | 25B. NAME OF REGISTRAR<br><u>James E. ...</u>   |  | 25C. FUNERAL DIRECTOR<br><u>Surgeon Funeral Home, Balt, Md.</u>   |  | ADDRESS<br><u>Water ...</u>   |  |





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| L-625 69 10700   |                         |   |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. 69 10700   |  |
|--|-------------------------|---|--|---|--|---|--|
| BIRTH NO.  |                         |   |  | CERTIFICATE OF DEATH  |  |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>AGNES LARSON</b>   |                         |   |  | 2. DATE AND HOUR OF DEATH<br><b>10-30-69 2:55 A.M.</b>  |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                         |   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>301</b>  |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>90 Harbor View Nursing Center</b>   |                         |   |  | C. CITY OR TOWN<br><b>Baltimore</b>   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |                         |   |  | E. STREET AND NUMBER<br><b>343 S. Dallas Court</b>  |  |   |  |
| 5. SEX<br><b>Female</b>  | 6. RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>8-8-88</b>   | 9. AGE (In years lost birthday)<br><b>81</b> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                     |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSE WIFE</b>   |                         |   |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                         |   |  |   |  |   |  |
| 13. FATHER'S NAME<br><b>JOSEPH HOPA</b>  |                         |   |  | 14. MOTHER'S MAIDEN NAME<br><b>ANNA KICA</b>  |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>  |                         |   |  | 16. SOCIAL SECURITY NO.<br><b>NO/VE</b>   |  | 17. INFORMANT ADDRESS<br><b>FRANCES ZANK 114 W 3RD ST 21225</b>                               |  |
| 18. <b>174 X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)<br><b>CANCER of breast, Rt. with metastasis</b>   |                         |   |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <b>Malnutrition</b> |  |   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b>  |                         |   |  |   |  |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |                         |   |  |   |  |   |  |
| 19A. DATE OF OPERATION<br><b>0</b>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><b>No</b>  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |  |   |  |
| 21D. TIME OF INJURY (A APPROX.)<br>(Month) (Day) (Year) (Hour)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |  |   |  |
| 22. I certify that (this hospital) attended the deceased from <b>9-19 1969</b> to <b>10-30 1969</b> , that (we) last saw the deceased alive on <b>10-30 1969</b> and that In (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |   |  |   |  |   |  |
| 23A. SIGNATURE<br><b>MANUEL A. GONGON, M.D.</b>  |                         |   |  | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>         |  | 23B. DATE SIGNED<br><b>10-30-69</b>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>MANUEL A. GONGON, M.D.</b>  |                         |   |  | 23D. ADDRESS<br><b>5701 THE ALAMEDA, BALTO. MD 21212</b>  |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                         | 24B. DATE<br><b>NOV 3 1969</b>  |  | 24C. NAME of CEMETERY or CREMATORY<br><b>HOLY CROSS CEMETERY</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>GERMAN HILL RD MD</b>                     |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 31 1969</b>  |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, MD</b>   |  | 25C. FUNERAL DIRECTOR<br><b>THE DIRPESL BROS INC 1800 E LOMBARD ST</b>  |  | ADDRESS   |  |

13

27

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JOSEPH WIFE

JOSEPH WIFE

ANNA WIFE

JOSEPH WIFE

NO

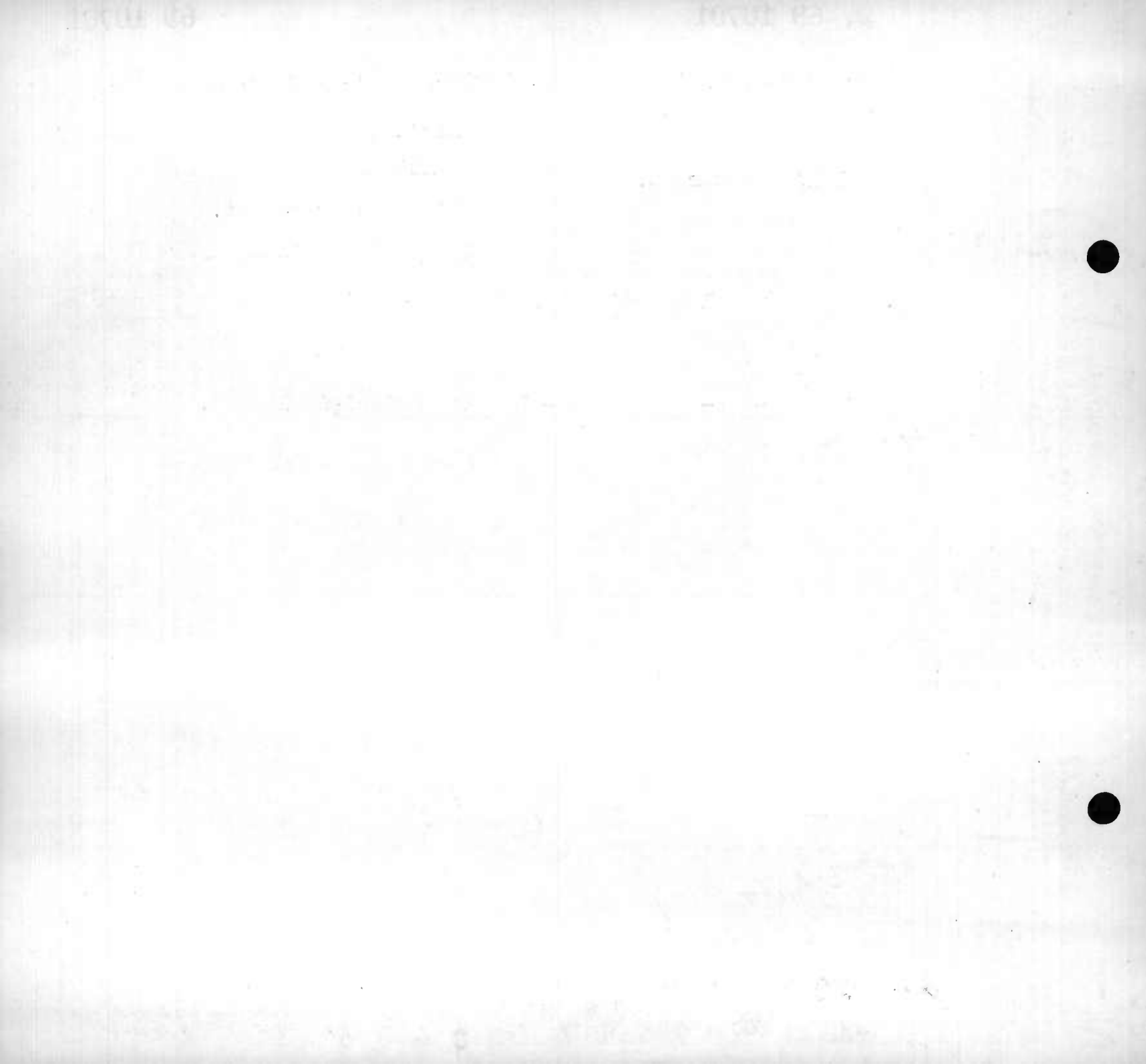
JOSEPH WIFE

ANNA WIFE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                     |   |   | REG. NO. <span style="float: right;">69 10701</span>                      |   |
|---|---------------------|---|---|---|---|
| BIRTH NO. <span style="float: right;">69 10701</span>   |                     |   |   | CERTIFICATE OF DEATH  |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Margaret R. Sudnikavich (Sudnikvich)</b>  |                     |   | 2. DATE AND HOUR OF DEATH<br><b>October 28, 1969 11:20 p.m.</b>   |   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><br><b>00 1414 Webster St.</b>   |                     |   | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>2401</b><br>C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>1434 Richardson St.</b> |   |   |
| 5. SEX<br><b>F</b>  | 6. RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>8/30/95</b>  | 9. AGE (In years last birthday)<br><b>74</b>                              | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Charwomen</b>   |                     | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>1st National Bank</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Austria</b>               | 12. CITIZEN OF WHAT COUNTRY?<br><b>Austria</b>            |
| 13. FATHER'S NAME<br><b>Unknown</b>   |                     |   | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                     | 16. SOCIAL SECURITY NO.<br><b>220-03-3124</b>   |   | 17. INFORMANT<br><b>Ann Principio 1203 N. Patterson Park Avenue</b>       |   |
| 18. <b>412.3 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.      |                     |   | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <b>Coronary Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) <b>Arteriosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) _____<br><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                     |   |   |   |   |
| 19A. DATE OF OPERATION<br><b>0</b>  |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |   | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>1967</b> 19 to <b>Oct. 28</b> 19 <b>69</b> , that (I) (we) lost <b>lost</b> saw the deceased alive on <b>Oct. 17</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                     |   |   |   |   |
| 23A. SIGNATURE<br><b>[Signature]</b>  |                     |   |   | 23B. DATE SIGNED<br><b>10/31/69</b>                                       |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>R. LOZDA</b>   |                     | 23D. ADDRESS<br><b>1225 S. Ches. St. Balt. Md. 21224</b>  |   |   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                     | 24B. DATE<br><b>11/1/69</b>   |   | 24C. NAME OF CEMETERY<br><b>Holy Trinity Russian Independent Orthodox</b> |   |
| 24D. LOCATION<br><b>Howard, Maryland</b>  |                     | 24E. FUNERAL DIRECTOR<br><b>Charles E. Stevens Funeral Home, Inc.</b>   |   |   |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 31 1969</b>   |                     | 25B. NAME OF REGISTRAR<br><b>[Signature]</b>  |   |   |   |
| 25C. FUNERAL DIRECTOR ADDRESS<br><b>8601 E. Fort Avenue</b>   |                     |   |   |   |   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. of a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

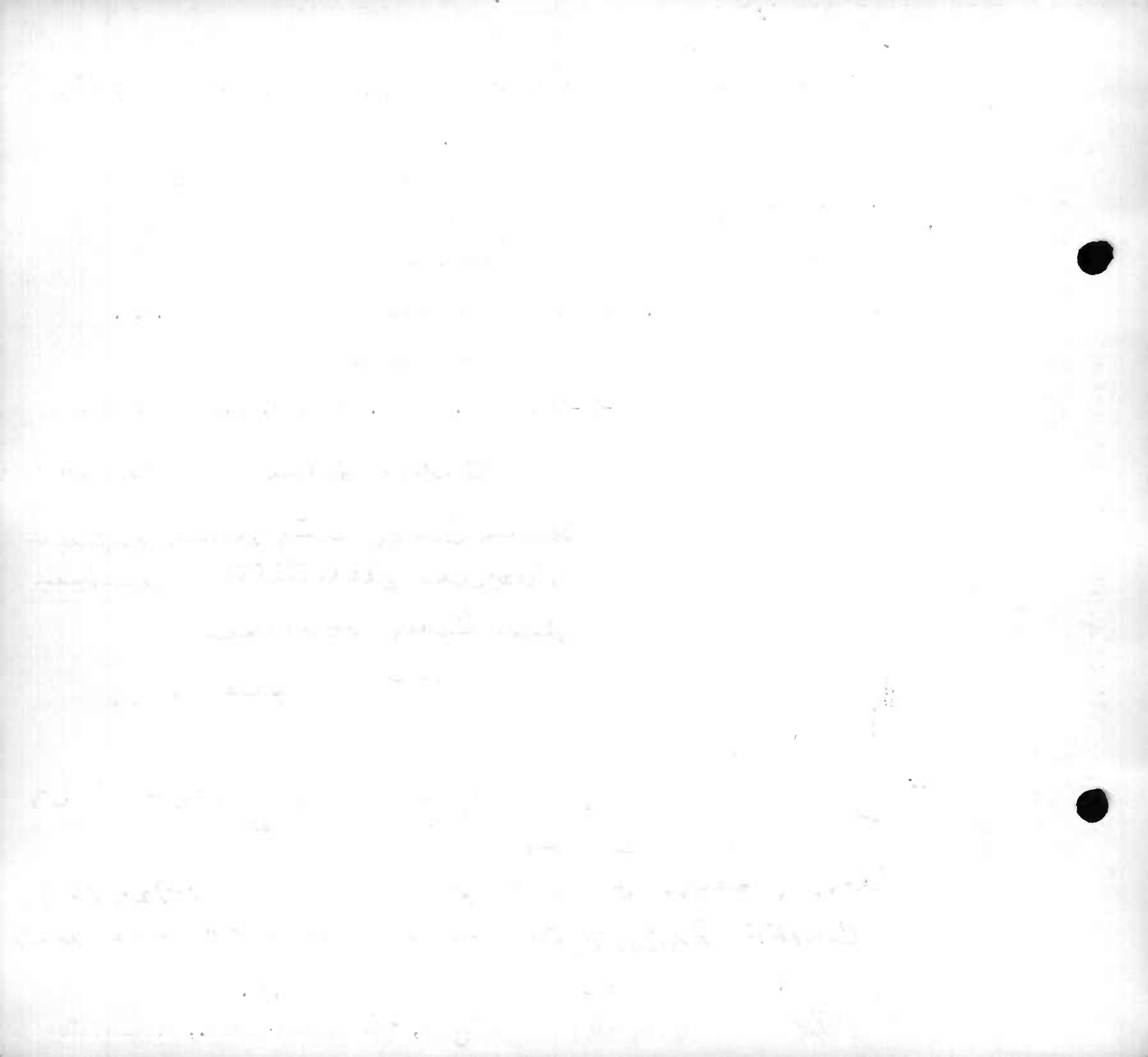
|  |                  |  |  |
|--|------------------|--|--|
| <div style="display: flex; justify-content: space-between;"> <span>E-120</span> <span>69 10702</span> </div> <div style="display: flex; justify-content: space-between;"> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> <span>CERTIFICATE OF DEATH</span> </div>   |                  | REG. NO. <b>69 10702</b>   |  |
| BIRTH NO. _____<br>1. NAME OF DECEASED<br>(Type or Print) <i>Edeline Epps</i>  |                  | 2. DATE AND HOUR OF DEATH<br><i>10/26/69</i> <i>1045</i> P. M.   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><i>Harbor View Nursing Home</i><br><i>90 1213 Light St</i>  |                  | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <i>MD</i> B. COUNTY <i>Balto city</i><br>C. CITY OR TOWN <i>Balto</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <i>1942 N. Paulman St</i> |  |
| 5. SEX <i>F</i>  | 6. RACE <i>C</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <i>4/1/02</i>           |
| 9. AGE (In years last birthday) <i>67</i>  |                  | 10. UNDER 1 Yr. Months _____ Days _____  | 11. UNDER 24 Hrs. Hours _____ Min. _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Kitchen</i>  |                  | 10B. KIND OF BUSINESS OR INDUSTRY _____  |  |
| 11. BIRTHPLACE (State or foreign country)<br><i>Virginia</i>   |                  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A</i>   |  |
| 13. FATHER'S NAME<br><i>George Sacatel</i>   |                  | 14. MOTHER'S MAIDEN NAME<br><i>Rachel Downing</i>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>No</i>  |                  | 16. SOCIAL SECURITY NO.<br><i>229-10-1278</i>  |  |
| 17. INFORMANT<br><i>Daughter</i>   |                  | ADDRESS<br><i>3215 Piedmont Ave</i>  |  |
| 18. <i>431.9 I</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><i>Cerebral Hemorrhage</i><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><i>Chronic Brain Syndrome</i><br>(C) DUE TO, OR AS A CONSEQUENCE OF:<br><i>Cerebral art. Sclerosis</i><br><br><i>Atherosclerosis</i>                                   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>4 hr</i>  |  |
| 19A. DATE OF OPERATION _____   |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____   |  |
| 20A. AUTOPSY? (Yes or No) _____  |                  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____   |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____   |                  | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____  |  |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                  | 21F. HOW DID INJURY OCCUR? _____   |  |
| 22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>10/21</i> <i>1969</i> to <i>10/26</i> <i>1969</i> , that (I) ( <del>was</del> ) lost saw the deceased alive on <i>10/24</i> <i>1969</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>Was</del> ) ( <del>did</del> ) (did not) view the body after death. |                  |  |  |
| 23A. SIGNATURE<br><i>Kenneth Kralewitz MD</i>  |                  | 23B. DATE SIGNED<br><i>10/27/69</i>  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><i>Kenneth Kralewitz</i>   |                  | 23D. ADDRESS<br><i>1213 Light St.</i>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |                  | 24B. DATE<br><i>10-29-69</i>   |  |
| 24C. NAME OF CEMETERY OR CREMATORY<br><i>Mt. Calvary</i>   |                  | 24D. LOCATION (City, town, or county) (State)<br><i>Baltimore, Maryland</i>  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>OCT 31 1969</i>  |                  | 25B. NAME OF REGISTRAR<br><i>Robert E. Taylor, Jr.</i>   |  |
| 25C. FUNERAL DIRECTOR<br><i>Charles R. Law</i>   |                  | ADDRESS<br><i>802 Madison Ave.</i>   |  |

1942 Pelman Pl.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |                          |   |                                     | REG. NO. <b>69 10703</b>  |   |
|--|--------------------------|---|-------------------------------------|---|---|
| BIRTH NO. <b>0-210</b>   |                          | <b>69 10703</b>   |                                     | <b>CERTIFICATE OF DEATH</b>   |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>JOHN THOMAS O'KEEFE</b>  |                          | 2. DATE AND HOUR OF DEATH<br><b>10/29/69 7:15 A.M.</b>  |                                     |   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                          | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)   |                                     |   |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>40 St. Agnes Hospital</b>   |                          | A. STATE<br><b>Md.</b>  |                                     | B. COUNTY<br><b>Baltimore</b>   |   |
| IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION   |                          | C. CITY OR TOWN<br><b>Baltimore</b>   |                                     | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
|  |                          | E. STREET AND NUMBER<br><b>504 Glen Allen Drive</b>   |                                     |   |   |
| 5. SEX<br><b>Male</b>  | 6. RACE<br><b>Female</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12/20/02</b> | 9. AGE (In years last birthday)<br><b>66</b>  | If Under 1 Yr. Months Days<br>If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Policeman</b>  |                          | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Balto. City Police</b>  |                                     | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                  |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                          | 13. FATHER'S NAME   |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Mary Donnelly</b>  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>  |                          | 16. SOCIAL SECURITY NO.<br><b>220-44-6220</b>   |                                     | 17. INFORMANT<br><b>Mrs. John T. O'Keefe, 504 Glen Allen Drive</b>                            |   |
| 18. <b>412.3 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Coronary artery disease</b>   |                          | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>Coronary artery disease</b>   |                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 weeks</b>                                |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Coronary artery disease</b>   |                          | (B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>Coronary artery disease</b>   |                                     | <b>3 weeks</b>  |   |
| (C) DUE TO, OR AS A CONSEQUENCE OF:<br><b>Coronary artery disease</b>  |                          |   |                                     | <b>3 weeks</b>  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>Coronary artery disease</b>   |                          |   |                                     |   |   |
| 19A. DATE OF OPERATION<br><b>2</b>   |                          | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                     | 20A. AUTOPSY? (Yes or No)<br><b>Yes</b>   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                          | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                     | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                   |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                          | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                                     | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10/10/69</b> to <b>10/28/69</b> that (I) (we) last saw the deceased alive on <b>10/27/69</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                          |   |                                     |   |   |
| 23A. SIGNATURE<br><b>Cliff Ratliff Jr.</b>   |                          | DEGREE<br><b>CLIFF RATLIFF JR.</b>  |                                     | 23B. DATE SIGNED<br><b>10/29/69</b>   |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>CLIFF RATLIFF JR.</b>   |                          | DEGREE<br><b>CLIFF RATLIFF JR.</b>  |                                     | 23D. ADDRESS<br><b>4605 EDMONDSON AVE #249</b>  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                          | 24B. DATE<br><b>10/31/69</b>  |                                     | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Crestlawn Cemetery</b>                               |   |
| 24D. LOCATION<br><b>Baltimore, Md.</b>   |                          | 24E. DATE REC'D BY HEALTH DEPT.<br><b>OCT 31 1969</b>   |                                     | 24F. NAME OF REGISTRAR<br><b>Robert E. Taylor</b>   |   |
| 24G. FUNERAL DIRECTOR<br><b>Witzke, 1630 Edmondson ave., Catonsville</b>   |                          | 24H. ADDRESS<br><b>Witzke, 1630 Edmondson ave., Catonsville</b>   |                                     | 24I. ADDRESS<br><b>Witzke, 1630 Edmondson ave., Catonsville</b>                               |   |

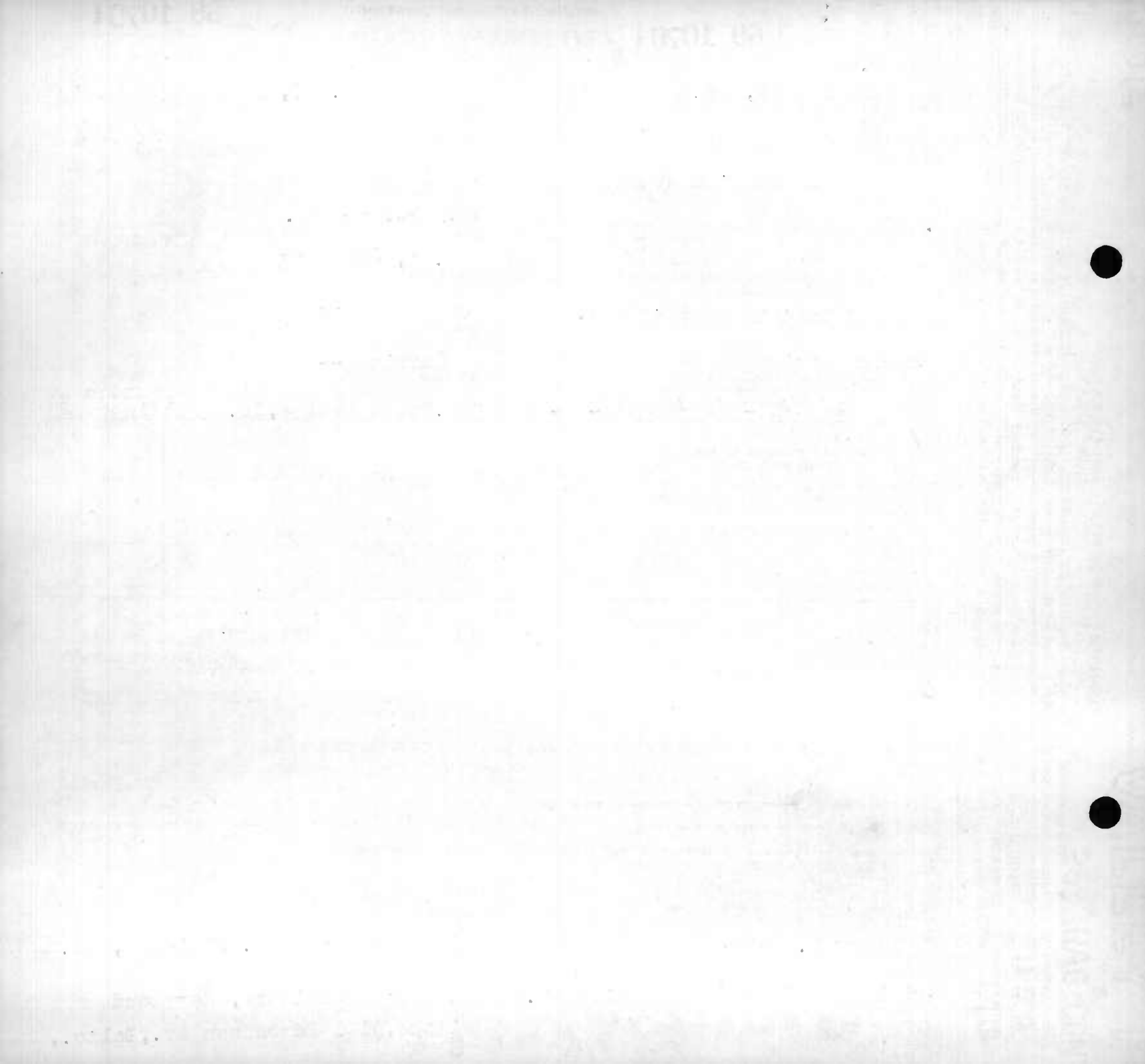




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

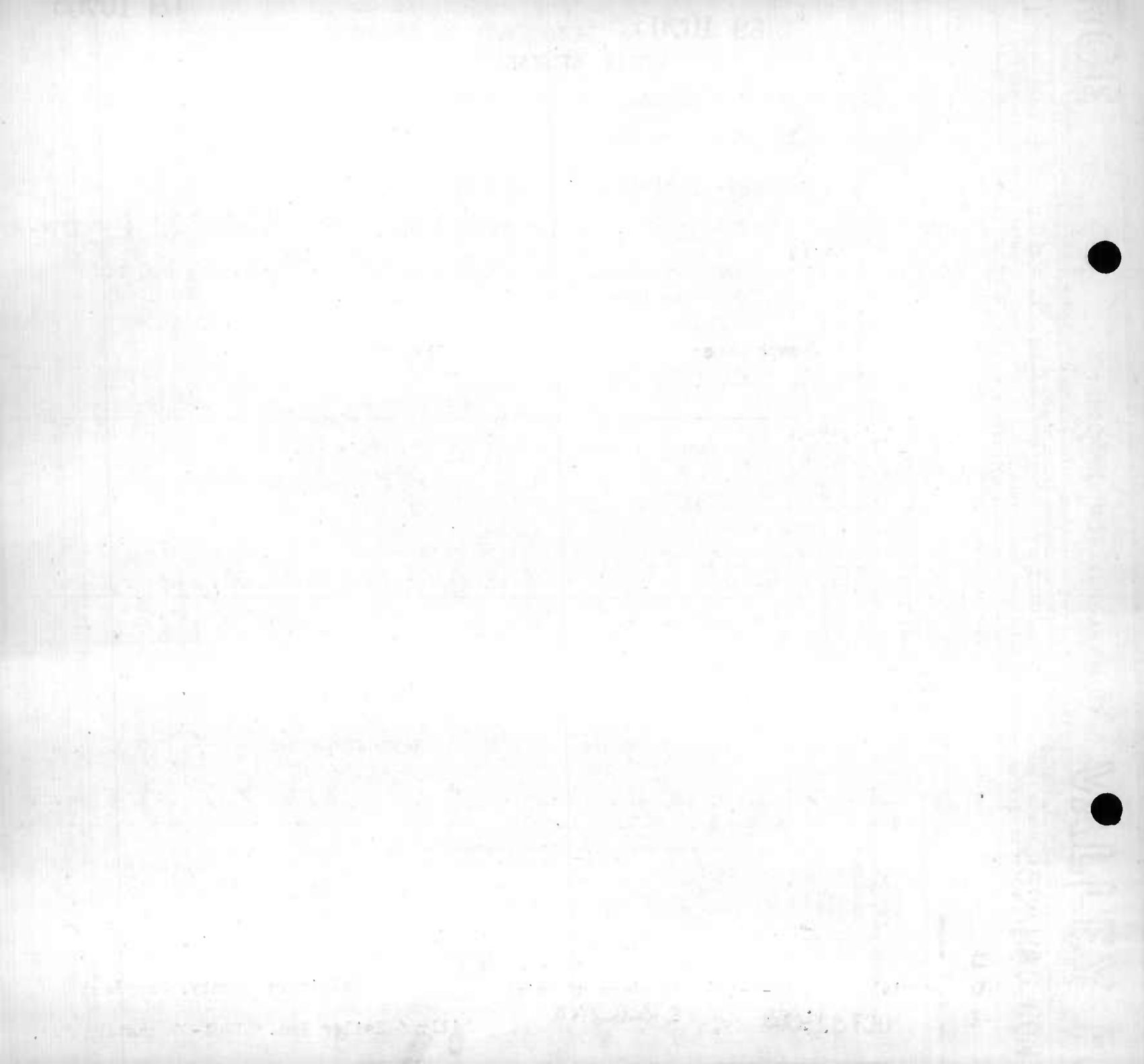
| BALTIMORE CITY HEALTH DEPARTMENT   |                         |   |  | 69 10704  |   | REG. NO. 69 10704  |  |
|--|-------------------------|---|--|---|---|--|--|
| BIRTH NO. <u>P-620</u>   |                         |   |  | 69 10704 CERTIFICATE OF DEATH   |   |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>John Preiss, Sr.</u>   |                         |   |  | 2. DATE AND HOUR OF DEATH<br><u>Oct. 27, 1969</u>   <u>8:00 A.M.</u>  |   |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><br><u>4022 Cranston Avenue</u>   |                         |   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>A. STATE <u>Maryland</u><br>B. COUNTY <u>1608</u><br>C. CITY OR TOWN <u>Baltimore</u><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <u>4022 Cranston Ave.</u> |   |  |  |
| 5. SEX<br><u>Male</u>  | 6. RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Nov. 11, 1895</u> | 9. AGE (In years last birthday)<br><u>73</u>  | 10. Under 1 Yr. Months: Days: Hours: Min. | 11. Under 24 Hrs. Hours: Min.  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired Captain</u>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Fire Dept.</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>New York City</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                             |  |
| 13. FATHER'S NAME<br><u>Charles Preiss</u>   |                         |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Carrie --</u>  |   |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>Yes</u> <u>4/28/17-5/29/19</u>  |                         | 16. SOCIAL SECURITY NO.<br><u>217-40-5166</u>   |  | 17. INFORMANT<br><u>Mrs. Ethel Preiss, Sr.</u> ADDRESS <u>4022 Cranston Av Baltimore 29</u>   |   |  |  |
| 18. <u>156.1</u> I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.<br><br><u>II</u><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><u>Arterioscl. Cardio Vase. disease</u> |                         |   |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><u>Carcinoma of Common Bile duct</u><br><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) _____   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 1/2 yrs.</u>      |  |
| 19A. DATE OF OPERATION<br><u>0</u>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><u>No</u>  |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?  |   |  |  |
| 22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>11-17-1967</u> to <u>10-27-1969</u> , that (I) ( <del>we</del> ) lost saw the deceased alive on <u>10-26-1969</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.   |                         |   |  |   |   |  |  |
| 23A. SIGNATURE<br><u>Harry L. Knipp</u>  |                         |   |  | 23B. DATE SIGNED<br><u>10-28-69</u>   |   | 23C. PHYSICIAN'S NAME (Type)<br><u>Harry L. Knipp</u>                  |  |
| 23D. ADDRESS<br><u>4116 Edmondson Ave. Baltimore, Md. 21229</u>  |                         | 23E. NAME OF REGISTRAR<br><u>Witzke, 4101 Edmondson Av., Balto.,</u>  |  |   |   |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                         | 24B. DATE<br><u>10/30/69</u>  |  | 24C. NAME OF CEMETERY or CREMATORY<br><u>Lorraine Pk. Garden Crypt Baltimore, Maryland</u>  |   | 24D. LOCATION (City, town, or county) (State)<br><u>Baltimore, Md.</u> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>OCT 31 1969</u>  |                         | 25B. NAME OF REGISTRAR<br><u>Charles E. Knipp</u>   |  | 25C. FUNERAL DIRECTOR<br><u>Witzke, 4101 Edmondson Av., Balto.,</u>   |   |  |  |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

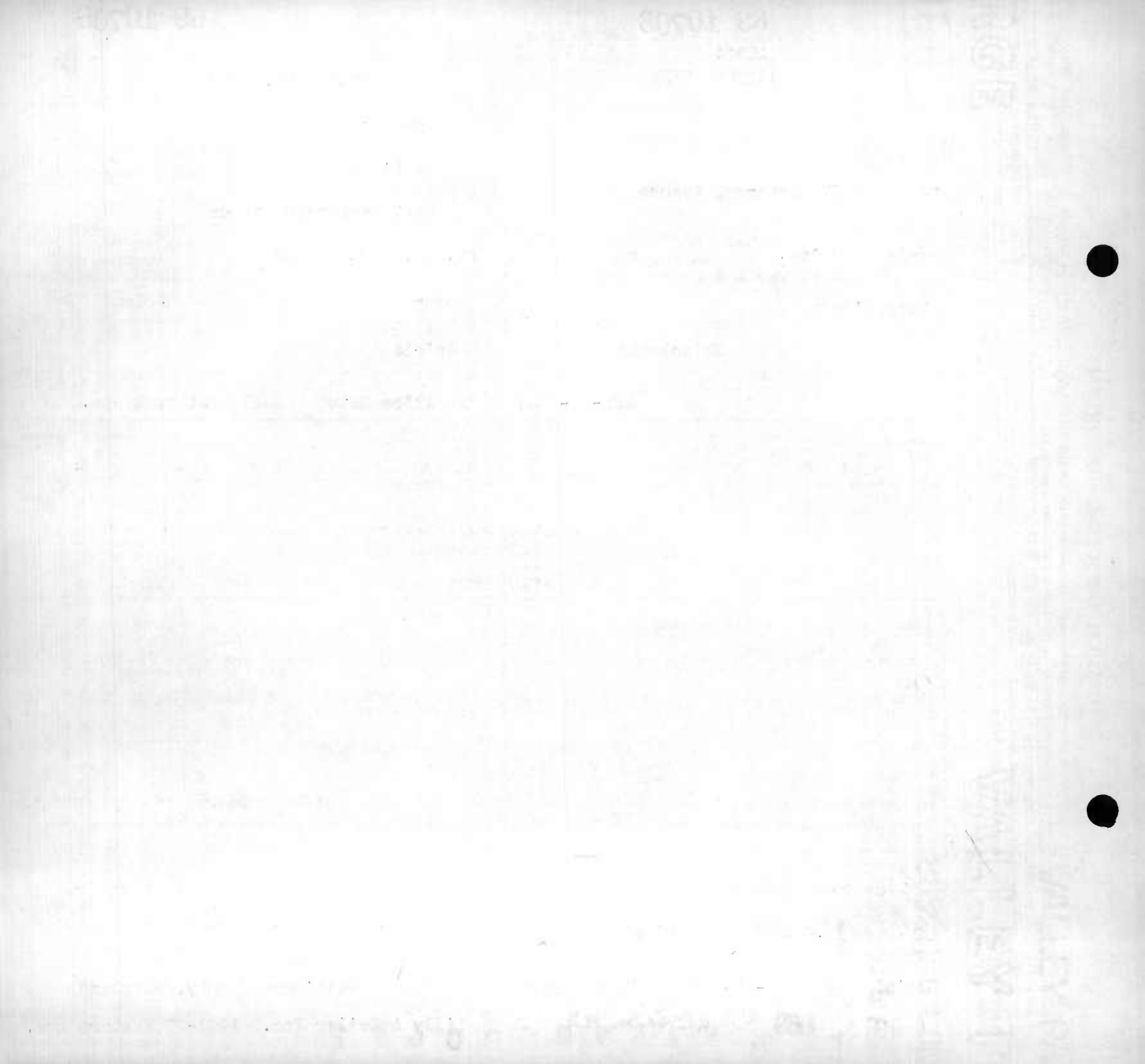
| 69 10705   |  |  |  | BALTIMORE CITY HEALTH DEPARTMENT  |  |   |  | 69 10705  |  |   |  |
|--|--|--|--|---|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH   |  |  |  |   |  |   |  | REG. NO.  |  |   |  |
| BIRTH NO.  |  |  |  | 1. NAME OF DECEASED<br>(Type or Print) <b>ANGELA SISOLAK</b>  |  |   |  | 2. DATE AND HOUR OF DEATH<br><b>OCTOBER 29/69 9:20 P.M.</b>   |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |  |  |   |  |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>2609</b> |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>NORTH CHARLES GEN. HOSP.</b>  |  |  |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |  |   |  | C. CITY OR TOWN<br><b>BALTIMORE</b>   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 5. SEX<br><b>F</b>   |  |  |  | 6. RACE<br><b>White</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>10-14-1886</b>   |  | 9. AGE (In years last birthday) <b>83</b>   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>  |  |  |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>CZECHOSLOVAKIA</b>  |  |   |  | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME<br><b>Joseph Nemac</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Theresa</b>  |  |   |  |   |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces?<br>(Yes, no or unknown) (If yes, give war or dates of service)  |  |  |  | 16. SOCIAL SECURITY NO.<br><b>213-16-7506</b>   |  | 17. INFORMANT<br><b>HOSPITAL RECORD</b>   |  |   |  | ADDRESS   |  |
| 18. <b>562.11</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>Bilat. Bronchopneumonia</b>   |  |  |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Ruptured diverticulitis, colon</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>Localized peritonitis</b><br>(C) <b>Atherosclerotic heart dis.</b> |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Recent</b>   |  |   |  |
| II   |  |  |  |   |  |   |  |   |  |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |  |  |   |  |   |  |   |  |   |  |
| 19A. DATE OF OPERATION<br><b>2</b>   |  |  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20A. AUTOPSY? (Yes or No)<br><b>Yes</b>   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>Yes</b>            |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)  |  |  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |   |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |  |   |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |  |  |  | 21E. INJURY OCCURRED<br>White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>   |  |   |  | 21F. HOW DID INJURY OCCUR?  |  |   |  |
| 22. I certify that <del>the</del> (this hospital) attended the deceased from <b>Oct 10</b> 19 <b>69</b> to <b>Oct 29</b> 19 <b>69</b> , that <del>we</del> (we) last saw the deceased alive on <b>Oct 29</b> 19 <b>69</b> and that in (my) <del>the</del> opinion death occurred on the date and hour and from the causes stated above, <del>it</del> (We) (did) <del>did not</del> view the body after death. |  |  |  |   |  |   |  |   |  |   |  |
| 23A. SIGNATURE<br><b>Benedicto J. Garin</b>  |  |  |  |   |  |   |  | 23B. DATE SIGNED<br><b>10/29/69</b>   |  |   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>BENEDICTO J. GARIN</b>  |  |  |  |   |  |   |  | 23D. ADDRESS<br><b>NORTH CHARLES GEN. HOSP.</b>   |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |  |  | 24B. DATE<br><b>11-3-1969</b>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Gardens of Faith</b>   |  |   |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore County, Maryland</b>            |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 31 1969</b>  |  |  |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Bailey, M.D.</b>   |  |   |  | 25C. FUNERAL DIRECTOR ADDRESS<br><b>Lilly &amp; Zeiler Inc. 1901-07 Eastern Ave.</b>  |  |   |  |



FUNERAL DIRECTOR: IMPORTANT

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|   |                  |   |  |  |  |
|---|------------------|---|--|--|--|
| 69 10706  |                  | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH  |  | 69 10706   |  |
| BIRTH NO.   |                  | AGATA   |  | REG. NO.   |  |
| 1. NAME OF DECEASED<br>(Type or Print)  |                  |   | 2. DATE AND HOUR OF DEATH  |  |  |
| AGATHA BISH   |                  |   | October 28, 1969   |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><br>00 6827 Eastbrook Avenue  |                  |   | A. STATE<br>Maryland<br>B. COUNTY<br>2605  |  |  |
|   |                  |   | C. CITY OR TOWN<br>Baltimore   |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
|   |                  |   | E. STREET AND NUMBER<br>6827 Eastbrook Avenue  |  |  |
| 5. SEX<br>Female  | 6. RACE<br>White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>Dec. 13, 1886  | 9. AGE (In years lost birthday)<br>82                                    | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                          |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife  |                  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br>Poland                      |  |
| 12. CITIZEN OF WHAT COUNTRY?<br>Poland  |                  | 13. FATHER'S NAME<br>Szlachetka   |  | 14. MOTHER'S MAIDEN NAME<br>Aniela                                       |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |                  | 16. SOCIAL SECURITY NO.<br>220-03-3883  |  | 17. INFORMANT<br>Mrs Alice Matuk   |  |
|   |                  |   |  | ADDRESS<br>6827 Eastbrook Ave.   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>412.3 I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |                  |   | CAUSE OF DEATH<br><br>(A) IMMEDIATE CAUSE<br>Cerebral vascular accident.<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) Arteriosclerosis heart disease<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) Anemia |  |  |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                  |   |  |  |  |
| MEDICAL CERTIFICATION   |                  |   |  |  |  |
| 19A. DATE OF OPERATION<br>0   |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from Oct 1967 to Oct 27 1969, that (I) (we) lost saw the deceased olive on Oct 27 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                  |   |  |  |  |
| 23A. SIGNATURE<br>Rafael A. Santayana   |                  |   |  | 23B. DATE SIGNED<br>Oct 29-69  |  |
| 23C. PHYSICIAN'S NAME (Type)<br>RAFAEL A. SANTAYANA   |                  |   |  | 23D. ADDRESS<br>6010 EASTERN AVE - BALTO. MD. 51224                      |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |                  | 24B. DATE<br>10-31-1969   |  | 24C. NAME of CEMETERY or CREMATORY<br>Holy Rosary                        |  |
| 24D. LOCATION<br>Baltimore County, Maryland   |                  | 25A. DATE REC'D BY HEALTH DEPT.<br>OCT 31 1969  |  |  |  |
| 25B. NAME OF REGISTRAR<br>Robert E. Fisher, M.D.  |                  | 25C. FUNERAL DIRECTOR<br>Lilly & Zeiler Inc. 1901-07 Eastern Ave.   |  |  |  |

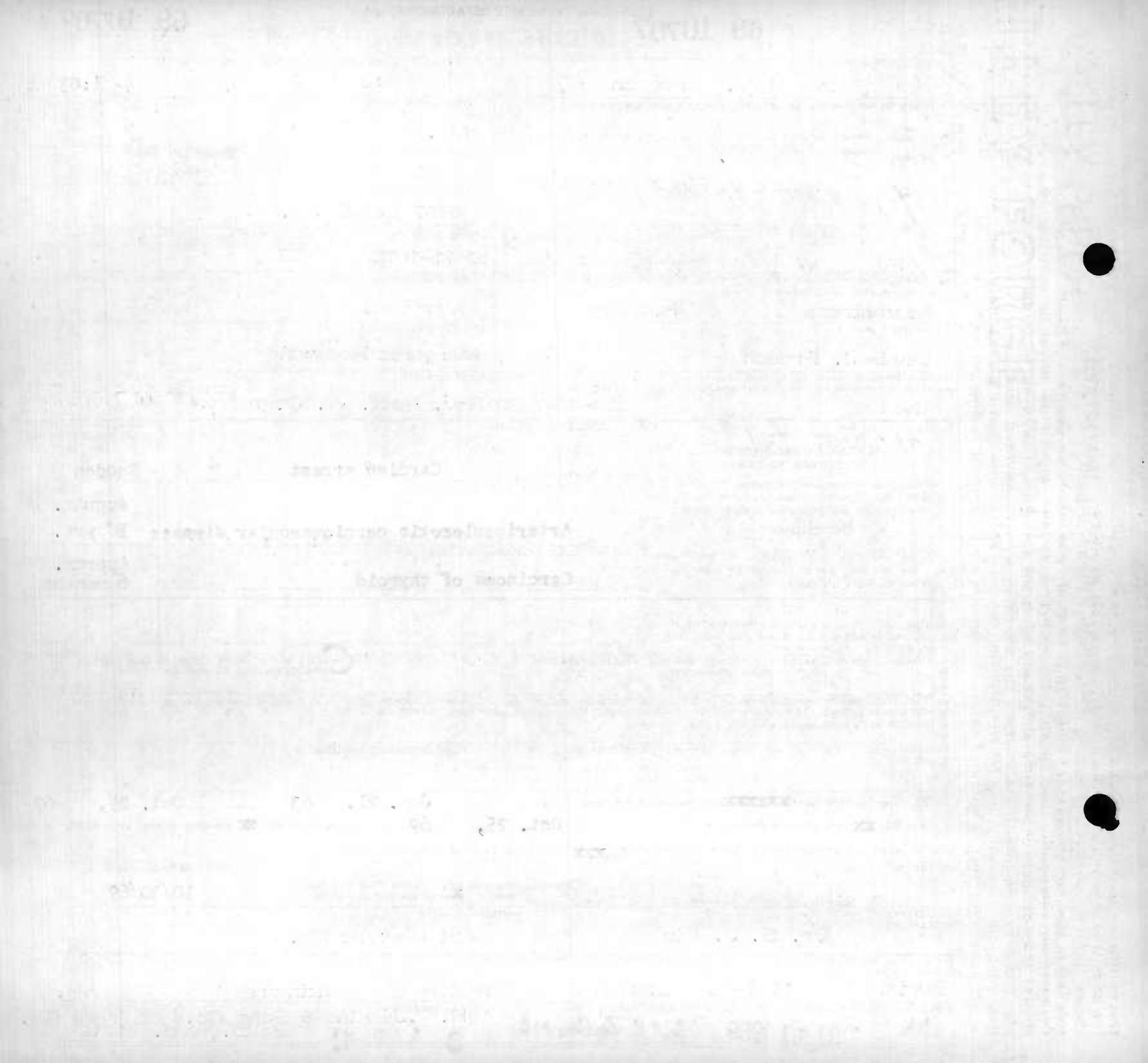


FUNERAL DIRECTOR: IMPORTANT

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| BALTIMORE CITY HEALTH DEPARTMENT  |   |   |                                       | REG. NO. <b>69 10707</b>  |
|---|---|---|---------------------------------------|---|
| BIRTH NO. <b>69 10707</b>   |   | <b>CERTIFICATE OF DEATH</b>   |                                       |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Ella M. Fresch</b>  |   | 2. DATE AND HOUR OF DEATH<br><b>10-30-69 1:03 A.M.</b>  |                                       |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>90 House in Pines (Belair)</b>  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b><br>B. COUNTY <b>2631</b>                       |                                       |   |
|   |   | C. CITY OR TOWN<br><b>Baltimore</b>   |                                       | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|   |   | E. STREET AND NUMBER<br><b>5837 Belair Rd.</b>  |                                       |   |
| 5. SEX<br><b>F</b>  | 6. RACE<br><b>W</b>                                     | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10-11-1872</b> | 9. AGE (In years lost birthday)<br><b>97</b>  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Seamstress</b>  |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Hutzlers</b>  |                                       | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 13. FATHER'S NAME<br><b>Lewis J. Fresch</b>   |                                       |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Margaret Rodawald</b>  |   | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                       |                                       |   |
| 16. SOCIAL SECURITY NO.<br><b>220-46-7420</b>   |   | 17. INFORMANT<br><b>Rev. Robt. W. Dorr</b>  |                                       |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><b>412.41 193X</b><br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Sudden</b>   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b>   |                                       |   |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |   | (B) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Approx. 10 yrs.</b>   |                                       |   |
|   |   | (C) <b>Carcinoma of thyroid</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Approx. 6 months</b>   |                                       |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |   |   |                                       |   |
| 19A. DATE OF OPERATION  |   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                       | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>                                 |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |   |   |                                       |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                       | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |   | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                                       | 21F. HOW DID INJURY OCCUR?  |
| 22. I certify that (I) <del>(the doctor)</del> attended the deceased from <b>Jan. 21, 1963</b> to <b>Oct. 25, 1969</b> , that (I) <del>(the doctor)</del> last saw the deceased alive on <b>Oct. 25, 1969</b> and that in (my) <del>(the doctor's)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(the doctor)</del> (did not) view the body after death. |   |   |                                       |   |
| 23A. SIGNATURE<br><b>S. J. Liu M.D.</b>   |   | 23B. DATE SIGNED<br><b>10/30/69</b>   |                                       | 23C. PHYSICIAN'S NAME (Type)<br><b>Dr. S. J. Liu</b>  |
| 23D. ADDRESS<br><b>5301 Harford Rd.</b>   |   | 23E. FUNERAL DIRECTOR<br><b>H.W. Jenkins &amp; Sons Co.</b>   |                                       |   |
| 23F. ADDRESS<br><b>4905 York Rd. Balto., Md. 21212</b>  |   |   |                                       |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 24B. DATE<br><b>11-1-69</b>                             | 24C. NAME OF CEMETERY or CREMATORY<br><b>Loudon Park Cemetery</b>   | 24D. LOCATION<br><b>Baltimore Md.</b> |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 31 1969</b>   | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher, M.D.</b> | 25C. FUNERAL DIRECTOR<br><b>H.W. Jenkins &amp; Sons Co.</b>   |                                       |   |







# FUNERAL DIRECTOR: IMPORTANT

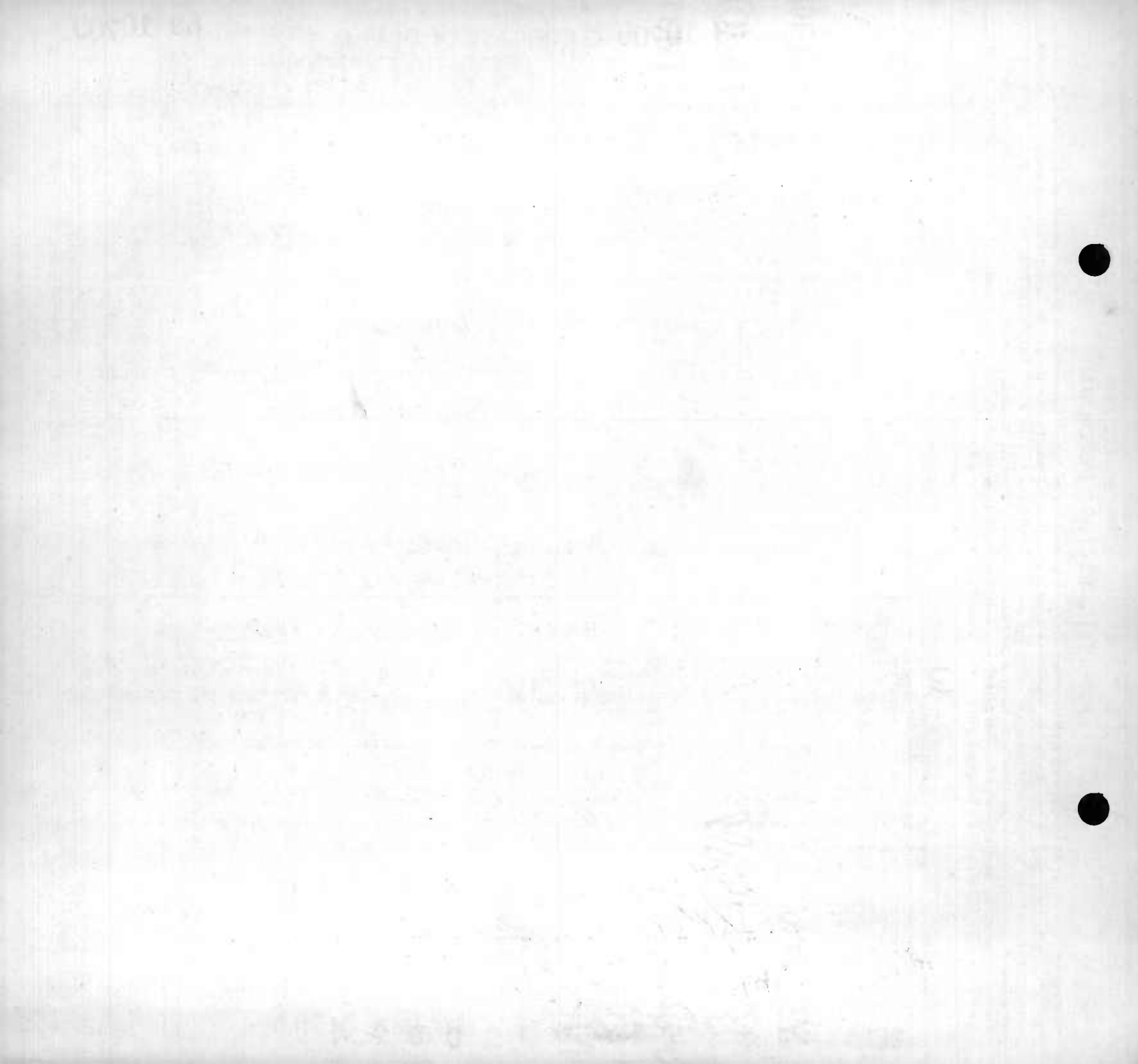
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department   |  |   |  | REG. NO. 69 10708   |                              |
|--|--|---|--|---|------------------------------|
| W-514  |  | 69 10708  |  | CERTIFICATE OF DEATH  |                              |
| BIRTH NO.  |  | 1. NAME OF DECEASED<br>(Type or Print)  |  | 2. DATE AND HOUR OF DEATH   |                              |
|  |  | MARIAN I. WOMBLE  |  | October 27, 1969 12:50 P.M.   |                              |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |  |   |                              |
| FULL NAME OF HOSPITAL OR INSTITUTION   |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                  |  | A. STATE B. COUNTY  |                              |
| 00 3404 Wabash Avenue  |  |   |  | MARYLAND  |                              |
|  |  | C. CITY OR TOWN   |  | D. INSIDE CITY LIMITS?  |                              |
|  |  | BALTIMORE   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                              |
|  |  | E. STREET AND NUMBER  |  |   |                              |
|  |  | 3404 Wabash Avenue  |  |   |                              |
| 5. SEX   | 6. RACE  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH   | 9. AGE (In years lost birthday)                                     | 10. CITIZEN OF WHAT COUNTRY? |
| Female   | Negro  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    | 4-30-1911  | 58  | U.S.A.                       |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)                           |                              |
| Housewife  |  | Home  |  | Cumberland, Virginia  |                              |
| 13. FATHER'S NAME  |  | 14. MOTHER'S MAIDEN NAME  |  |   |                              |
| Carey Deane  |  | Louise Deane  |  |   |                              |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |                              |
| No.  |  | 212-26-1939   |  | Mr. Joseph B. Womble  |                              |
|  |  |   |  | ADDRESS   |                              |
|  |  |   |  | Same  |                              |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH   |  | CAUSE OF DEATH  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |                              |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  |  | CARCINOMA (LUNG)  |  | UNKNOWN   |                              |
| ANTECEDENT CAUSES  |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                   |  |   |                              |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  | (B) DUE TO, OR AS A CONSEQUENCE OF:   |  |   |                              |
|  |  | (C) DUE TO, OR AS A CONSEQUENCE OF:   |  |   |                              |
| II   |  |   |  |   |                              |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |   |  |   |                              |
| 19A. DATE OF OPERATION   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20A. AUTOPSY? (Yes or No)   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |                              |
|  |  |   |  |   |                              |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |  |   |                              |
|  |  |   |  |   |                              |
| 21D. TIME OF INJURY (APPROX.)  | 21E. INJURY OCCURRED   | 21F. HOW DID INJURY OCCUR?  |  |   |                              |
|  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |   |  |   |                              |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 10/27/69, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |   |  |   |                              |
| 23A. SIGNATURE   |  | 23B. DATE SIGNED  |  |   |                              |
| N. Alan Harris, M.D.   |  | 10/28/69  |  |   |                              |
| 23C. PHYSICIAN'S NAME (Type)   |  | 23D. ADDRESS  |  |   |                              |
| N. ALAN HARRIS, M.D.   |  | 4200 EDMONDSON AVE. BALTO., MD.   |  |   |                              |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   | 24B. DATE  | 24C. NAME OF CEMETERY or CREMATORY  | 24D. LOCATION (City, town, or county) (State)                        |   |                              |
| Burial   | 11-1-69  | Bethlehem Bapt. Ch. Cem.  | Cumberland, Virginia   |   |                              |
| 25A. DATE REC'D BY HEALTH DEPT.  | 25B. NAME OF REGISTRAR   | 25C. FUNERAL DIRECTOR   |  | ADDRESS   |                              |
| OCT 31 1969  | Robert E. Taylor   | DORSON & BYETT  |  | F.H. 1701 Laurens St.   |                              |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

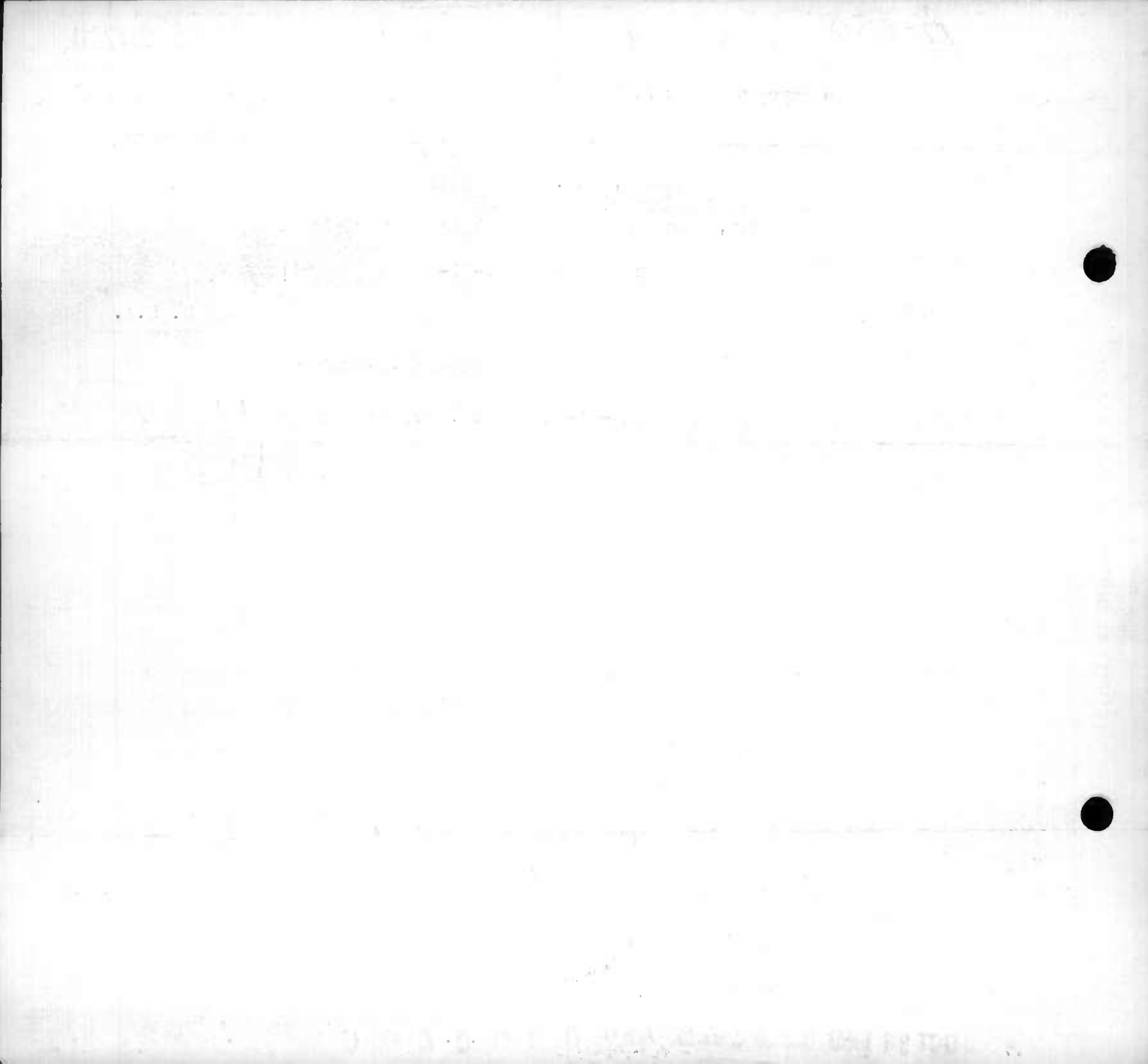
|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| M-200  |  | 69 10709   |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | REG. NO. 69 10709  |  |
| BIRTH NO.  |  |  |  | 1. NAME OF DECEASED<br>(Type or Print) <b>MAYES, FRED</b>  |  |  |  |
| 2. DATE AND HOUR OF DEATH<br><b>3-10-29-69 3:45 P.M.</b>   |  |  |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |  |  |
| 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>1604</b>  |  |  |  | 5. SEX <b>M</b> 6. RACE <b>NEGRO</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |
| C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  | E. STREET AND NUMBER <b>1128 MCKEAN AVE</b>  |  |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>   |  |  |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 11. BIRTHPLACE (State or foreign country) <b>Oxford, North Carolina</b>  |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |  |  |
| 13. FATHER'S NAME <b>Henry Mayes</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME <b>Nannie Mayes</b>   |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |  |  |  | 16. SOCIAL SECURITY NO. <b>217-14-3195</b>   |  | 17. INFORMANT <b>Mrs. Estell Robinson</b> ADDRESS <b>Same</b>            |  |
| 18. <b>532.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>CARDIAC ARREST.</b>   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>VENTRICULAR FIBRILLATION</b><br><b>MYOCARDIAL INFARCTION.</b>   |  |  |  |  |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |  |  | <b>BLEEDING DUODENAL ULCER</b>   |  |  |  |
| 19A. DATE OF OPERATION <b>10-28-69</b>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>G.I. BLEEDING</b>                                  |  | 20A. AUTOPSY? (Yes or No) <b>Yes</b>   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?     |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10-27-1969</b> to <b>10-29-1969</b> , that (I) (we) last saw the deceased alive on <b>10-29-1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 23A. SIGNATURE <b>P. Lal M.B.B.S.</b>  |  |  |  | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>  |  | 23B. DATE SIGNED   |  |
| 23C. PHYSICIAN'S NAME (Type) <b>PREM LAL M.B.B.S.</b>  |  |  |  | 23D. ADDRESS <b>LUTHERAN HOSPITAL 730 ASHBURTON ST. BALTO: MARYLAND</b>  |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burn</b>   |  | 24B. DATE <b>11/1/69</b>   |  | 24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem. Park</b>  |  | 24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b> |  |
| 25A. DATE REC'D BY HEALTH DEPT. <b>OCT 31 1969</b>   |  | 25B. NAME OF REGISTRAR <b>Robert E. ...</b>  |  | 25C. FUNERAL DIRECTOR <b>Horning Dyett F.H.</b>  |  | ADDRESS <b>1701 Laukens St.</b>  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| B-650   |                      | 69 10710  |                                    | BALTIMORE CITY HEALTH DEPARTMENT  |   | REG. NO. 69 10710      |   |
|---|----------------------|---|------------------------------------|---|---|------------------------|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>MAGGIE BRYAN</b>  |                      |   |                                    | 2. DATE AND HOUR OF DEATH<br><b>Oct 27, 69 11:25 a.m.</b>   |   |                        |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><b>Provident Hospital, Inc.<br/>1514 Division Street<br/>Baltimore, Maryland 21217</b>  |                      |   |                                    | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>Baltimore</b><br>C. CITY OR TOWN <b>Baltimore</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>1215 Cloverdale Road</b> |   |                        |   |
| 5. SEX<br><b>F</b>  | 6. RACE<br><b>N.</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1-10-78</b> | 9. AGE (In years last birthday)<br><b>91</b>  | 10. Under 1 Yr. Months: Days: Hours: Min. | 11. Under 24 Hrs. Min. | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Unemployed</b>  |                      |   |                                    | 10B. KIND OF BUSINESS OR INDUSTRY   |   |                        |   |
| 13. FATHER'S NAME<br><b>Plumber Alexander</b>   |                      |   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Hayes</b>  |   |                        |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                      |   |                                    | 16. SOCIAL SECURITY NO.<br><b>214-14-2459</b>   |   |                        |   |
| 17. INFORMANT<br><b>Mrs. Evelyn Butler</b>  |                      |   |                                    | ADDRESS<br><b>1215 Cloverdale</b>   |   |                        |   |
| 18. CAUSE OF DEATH<br><b>410.9 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br>19A. DATE OF OPERATION<br><b>10-25-69</b><br>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>NO</b><br>20A. AUTOPSY? (Yes or No)<br><b>NO</b><br>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>NO</b><br>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/><br>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>NO</b><br>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>NO</b><br>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br><b>NO</b><br>21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/><br>21F. HOW DID INJURY OCCUR?<br><b>NO</b><br>22. I certify that (I) (this hospital) attended the deceased from <b>10-25-69</b> to <b>10-27-69</b> and that (I) (we) last saw the deceased alive on <b>10-27-69</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.<br>23A. SIGNATURE<br><b>M. J. Shaf</b><br>23B. DATE SIGNED<br><b>27th Oct 69</b><br>23C. PHYSICIAN'S NAME (Type)<br><b>M. J. SHAF</b><br>23D. ADDRESS<br><b>Provident Hospital</b><br>24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b><br>24B. DATE<br><b>10-30-69</b><br>24C. NAME OF CEMETERY or CREMATORY<br><b>St. Lukes Church</b><br>24D. LOCATION (City, town, or county) (State)<br><b>Reisterstown Balto Md</b><br>25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 31 1969</b><br>25B. NAME OF REGISTRAR<br><b>John E. Taylor</b><br>25C. FUNERAL DIRECTOR<br><b>Frederick, Md</b><br>ADDRESS<br><b>111 263 W. Patrick St, Fred</b> |                      |   |                                    |   |   |                        |   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |  |  |  |  |   |  |  |  |   |
|--|--|--|--|--|---|--|--|--|---|
| BIRTH NO. <u>D-650</u>   |  |  |  |  | 69 10711  |  |  |  |   |
| 1. NAME OF DECEASED<br>(Type or Print)   |  |  |  |  | 2. DATE AND HOUR OF DEATH   |  |  |  |   |
| BROWN MARION   |  |  |  |  | October 27, 1969 7:30 P.M.  |  |  |  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) |  |  |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |  |  |  |  | A. STATE B. COUNTY  |  |  |  |   |
| Union Memorial Hospital  |  |  |  |  | MARYLAND  |  |  |  |   |
| 5. SEX   |  |  |  |  | 6. RACE   |  |  |  |   |
| FEMALE   |  |  |  |  | NEGRO   |  |  |  |   |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>  |  |  |  |  | 8. DATE OF BIRTH  |  |  |  |   |
| WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |  | 06-12-17  |  |  |  |   |
| 9. AGE (In years last birthday)  |  |  |  |  | 52  |  |  |  |   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |  |  |  | 11. BIRTHPLACE (State or foreign country)   |  |  |  |   |
| HOUSEWIFE  |  |  |  |  | NOT KNOWN   |  |  |  |   |
| 13. FATHER'S NAME  |  |  |  |  | 14. MOTHER'S MAIDEN NAME  |  |  |  |   |
| NOT KNOWN  |  |  |  |  | NOT KNOWN   |  |  |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |  |  |  |  | 16. SOCIAL SECURITY NO.   |  |  |  |   |
|  |  |  |  |  |   |  |  |  |   |
| 17. INFORMANT  |  |  |  |  | ADDRESS   |  |  |  |   |
| CARLTON BROWN (husband)  |  |  |  |  | SAME  |  |  |  |   |
| 18. CAUSE OF DEATH   |  |  |  |  |   |  |  |  |   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH   |  |  |  |  |   |  |  |  |   |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)               |  |  |  |  |   |  |  |  |   |
| ANTECEDENT CAUSES  |  |  |  |  |   |  |  |  |   |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  |  |  |  |   |  |  |  |   |
| <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonia</u></p> <p>(B) <u>Arteriosclerosis &amp; Vascular Disease</u></p> <p>(C) <u>Ox</u></p> |  |  |  |  |   |  |  |  |   |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |   |  |  |  |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                           |  |  |  |  |   |  |  |  |   |
| MEDICAL CERTIFICATION  |  |  |  |  |   |  |  |  |   |
| 19A. DATE OF OPERATION   |  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20A. AUTOPSY? (Yes or No)  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |  |   |
| 21D. TIME OF INJURY (APPROX.)  |  |  | 21E. INJURY OCCURRED   |  |   | 21F. HOW DID INJURY OCCUR?   |  |  |   |
| 22. I certify that (I) (this hospital) attended the deceased from 09-17-69 to October 27, 1969.  |  |  | that (I) (we) lost saw the deceased alive on October 27, 1969 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |   |  |  |  |   |
| 23A. SIGNATURE   |  |  | 23B. DATE SIGNED   |  |   |  |  |  |   |
| Miguel Karacuschansky M.D.   |  |  | October 27, 1969   |  |   |  |  |  |   |
| 23C. PHYSICIAN'S NAME (Type)   |  |  | 23D. ADDRESS   |  |   |  |  |  |   |
| Miguel KARACUSCHANSKY M.D.   |  |  | UNION MEMORIAL Hospital  |  |   |  |  |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |  |  | 24B. DATE  |  |   | 24C. NAME OF CEMETERY or CREMATORY                                       |  |  | 24D. LOCATION (City, town, or county) (State) |
| Burial   |  |  | 10/31/69   |  |   | Mt. Auburn Cem.  |  |  | Beth. Md.                                     |
| 25A. DATE REC'D BY HEALTH DEPT.  |  |  | 25B. NAME OF REGISTRAR   |  |   | 25C. FUNERAL DIRECTOR  |  |  | ADDRESS                                       |
| 10/31/69   |  |  | Robert E. Taylor, M.D.   |  |   | Wm. Mark   |  |  | 925 E North Ave                               |

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222

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |         |  |                  |   |                       |  |                        |
|---|---------|--|------------------|---|-----------------------|--|------------------------|
| D-600   |         | 69 10712   |                  | BALTIMORE CITY HEALTH DEPARTMENT  |                       | REG. NO. 69 10712  |                        |
| 1. NAME OF DECEASED<br>(Type or Print)  |         |  |                  | 2. DATE AND HOUR OF DEATH   |                       |  |                        |
| MITCHELL DREW   |         |  |                  | 1:20 pm 10/26/69  |                       |  |                        |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |         |  |                  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) |                       |  |                        |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><br>Lutheran Hospital of Maryland<br>46  |         |  |                  | A. STATE  |                       | B. COUNTY  |                        |
|   |         |  |                  | Maryland  |                       | 1538   |                        |
| C. CITY OR TOWN   |         |  |                  | D. INSIDE CITY LIMITS?  |                       |  |                        |
|   |         |  |                  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                   |                       |  |                        |
| E. STREET AND NUMBER  |         |  |                  | 3013 Chelsea Terrace  |                       |  |                        |
| 5. SEX  | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>               | 8. DATE OF BIRTH | 9. AGE (In years lost birthday)   | If Under 1 Yr. Months | If Under 24 Hrs. Days  | If Under 24 Hrs. Hours |
| M   | white   | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                       | Not known        | 60  |                       |  |                        |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |         | 10B. KIND OF BUSINESS OR INDUSTRY  |                  | 11. BIRTHPLACE (State or foreign country)   |                       | 12. CITIZEN OF WHAT COUNTRY?   |                        |
| Unemployed  |         |  |                  | Georgia   |                       |  |                        |
| 13. FATHER'S NAME   |         |  |                  | 14. MOTHER'S MAIDEN NAME  |                       |  |                        |
| Unknown   |         |  |                  | Unknown   |                       |  |                        |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |         | 16. SOCIAL SECURITY NO.  |                  | 17. INFORMANT ADDRESS   |                       |  |                        |
|   |         |  |                  | Ruth Stephens 3013 Chelsea Terrace  |                       |  |                        |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |         | CAUSE OF DEATH   |                  |   |                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                         |                        |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                  |         | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                      |                  |   |                       |  |                        |
|   |         | heavily tract infection<br>pneumonia   |                  |   |                       |  |                        |
|   |         | (B) DUE TO, OR AS A CONSEQUENCE OF:  |                  |   |                       |  |                        |
|   |         |  |                  | (C) DUE TO, OR AS A CONSEQUENCE OF:   |                       |  |                        |
|   |         |  |                  |   |                       |  |                        |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |         |  |                  |   |                       |  |                        |
| 19A. DATE OF OPERATION  |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                  | 20A. AUTOPSY? (Yes or No)   |                       | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                        |
| 0   |         | -  |                  | No  |                       |  |                        |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |                       |  |                        |
| -   |         | -  |                  | -   |                       |  |                        |
| 21D. TIME OF INJURY (APPROX.)   |         | 21E. INJURY OCCURRED   |                  | 21F. HOW DID INJURY OCCUR?  |                       |  |                        |
| -   |         | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |                  | -   |                       |  |                        |
| 22. I certify that (I) (this hospital) attended the deceased from 10/20/69 1969 to 10/26 1969, that (I) (we) lost saw the deceased alive on 1:20 pm 10/26 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |         |  |                  |   |                       |  |                        |
| 23A. SIGNATURE  |         |  |                  | 23B. DATE SIGNED  |                       |  |                        |
| Pharmacist  |         |  |                  | 10/26/69  |                       |  |                        |
| 23C. PHYSICIAN'S NAME (Type)  |         |  |                  | 23D. ADDRESS  |                       |  |                        |
| PRATIMA KHAISTAGIE  |         |  |                  | Lutheran Hospital   |                       |  |                        |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |         | 24B. DATE  |                  | 24C. NAME OF CEMETERY or CREMATORY  |                       | 24D. LOCATION (City, town, or county) (State)                        |                        |
| Burial  |         | 10/29/69   |                  | Mt. Auburn Cem.   |                       | Baltimore Md.  |                        |
| 25A. DATE REC'D BY HEALTH DEPT.   |         | 25B. NAME OF REGISTRAR   |                  | 25C. FUNERAL DIRECTOR   |                       | ADDRESS  |                        |
| 10/31/69  |         | [Signature]  |                  | [Signature]   |                       | 928 E NORTH AVE  |                        |



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 10713

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CYNTHIA M. YOUNG (MURRAY)

2. DATE  
OF  
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(If not in hospital or institution, give street  
address or location)

UNION MEMORIAL HOSPITAL (DOA)

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

October 29, 1969

5:55 A. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

1204

6. SEX

Female

7. RACE

Negro

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

6-8-50

10. AGE (In years  
lost birthday)

19

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

2113 Barclay Street

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

JOHN B. YOUNG

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

HESTER HOLLOMAN

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

JOHN YOUNG 2113 Barclay St.

19.

304.9

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

Narcotics Addiction

DUE TO, OR AS A CONSEQUENCE OF:

II  
ANTECEDENT CAUSESDISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/29/69

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

Nov 3 1969

24C. NAME of CEMETERY or CREMATORY

BALTO. NATIONAL CEM

24D. LOCATION

(City, town, or county)

(State)

BALTO. MD.

25A. DATE REC'D BY HEALTH DEPT.

OCT 31 1969

25B. NAME OF REGISTRAR

R. E. YOUNG, JR.

25C. FUNERAL DIRECTOR

ADDRESS

WM MARCH 928 E NORTH AVE

VS 177 from Dr/Kornblum

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| C-500  |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. <b>69 10714</b>  |  |
| BIRTH NO.  |  | 69 10714  |  | CERTIFICATE OF DEATH  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>RATHERINE A. CONWAY</b>  |  | 2. DATE AND HOUR OF DEATH<br><b>10-30-69 3:35 A.M.</b>  |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>2404</b> |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>South Baltimore Genl Hosp</b><br><b>3301 S. Hanover Street</b><br><b>Baltimore Maryland</b>   |  | C. CITY OR TOWN<br><b>Baltimore</b>   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 5. SEX <b>F</b>  |  | 6. RACE <b>white</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH<br><b>9-26-26</b>   |  | 9. AGE (in years last birthday) <b>43</b>   |  | If Under 1 Yr. Months Days<br>If Under 24 Hrs. Hours Min.   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>#</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore Md.</b>   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 13. FATHER'S NAME<br><b>John Eder</b>   |  |   |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Besai E</b>   |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                   |  |   |  |
| 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><b>Mrs. Joanna Bohle</b> ADDRESS <b>1722 Byrd St.</b>  |  |   |  |
| 18. <b>398X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)<br><b>Severe Congestive Heart Failure</b>  |  | CAUSE OF DEATH  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| ANTECEDENT CAUSES  |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Secondary to Rheumatic HF</b>  |  |   |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  | (B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>Disease</b>   |  |   |  |
| (C) _____  |  |   |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |   |  |   |  |
| 19A. DATE OF OPERATION<br><b>0</b>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)   |  |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |   |  |   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                               |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>12:30 am 10-21-19</b> to <b>3:35 am 10-30-1969</b> and that (I) (we) last saw the deceased alive on <b>3:35 am 10-30-19 69</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |   |  |   |  |
| 23A. SIGNATURE<br><b>Henry C. Cullen MD</b>  |  | 23B. DATE SIGNED<br><b>10-30-69</b>   |  | 23C. PHYSICIAN'S NAME (Type)<br><b>HENRY CULLEN MD</b>  |  |
| 23D. ADDRESS<br><b>3001 South Hanover St Baltimore</b>   |  |   |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>11 1 69</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven</b>   |  |
| 24D. LOCATION<br><b>Glen Burnie, A. A. Co. Md.</b>   |  |   |  |   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 31 1969</b>  |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor</b>   |  | 25C. FUNERAL DIRECTOR<br><b>Mc Cully</b> ADDRESS <b>130 E. Fort Ave</b>   |  |

2

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R-120

69 10715 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 10715

BIRTH NO.

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>PAUL REEVES</b>  |  |   |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> M.  |  |   |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>44 UNION MEMORIAL HOSPITAL</b><br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |  |   |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>October 28, 1969 9:50 A.</b>  |  |   |  |
| 6. SEX<br><b>Male</b>  |  |   |  | 7. RACE<br><b>White</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |
| 9. DATE OF BIRTH<br><b>Dec 11, 1969</b>  |  |   |  | 10. AGE (In years last birthday)<br><b>55</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>   |  |
| 12. CITIZEN OF WHAT COUNTRY?   |  |   |  | 13. FATHER'S NAME<br><b>Wallace Reeves.</b>  |  |   |  |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Welder</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br><b>Lillie ?</b>  |  |   |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>-----</b>  |  |   |  | 17. SOCIAL SECURITY NO.<br><b>212-12-7541</b>  |  | 18. INFORMANT ADDRESS<br><b>Pauline E. Reeves, 2647 Greenmount Ave.</b>   |  |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><b>412.4</b><br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |  |   |  | CAUSE OF DEATH<br><b>Arteriosclerotic Cardiovascular Disease</b><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) DUE TO, OR AS A CONSEQUENCE OF: |  |   |  |
| 20A. DATE OF OPERATION   |  |   |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |   |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  |   |  |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |   |  | 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |  |   |  |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 22F. HOW DID INJURY OCCUR?   |  |   |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>  |  |   |  | Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>                                  |  |   |  |
| DATE SIGNED<br><b>10/28/69</b>   |  |   |  |  |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>Oct. 31, 1969</b>                       |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Lorraine Park</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>Balto Co.</b>   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 31 1969</b>  |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b> |  | 25C. FUNERAL DIRECTOR<br><b>Paul E. Chenoweth jr</b>   |  | ADDRESS<br><b>3615 Chestnut Ave.</b>  |  |

WALLER BOING



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                            |   |  | REG. NO. <b>69 10716</b>                         |
|---|----------------------------|---|--|--|
| <b>U-541</b><br><b>69 10716</b><br><b>CERTIFICATE OF DEATH</b>  |                            | <b>BIRTH NO.</b><br><b>1. NAME OF DECEASED</b><br>(Type or Print) <b>IDA UMLAUFF</b>  |  |  |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><br><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>MONTEBELLO STATE Hospital</b>   |                            | <b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD</b> B. COUNTY <b>BALTIMORE</b><br><b>10-29-1969</b> <b>10:40 P.M.</b><br>C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>3508 Chestnut Ave.</b> |  |  |
| <b>5. SEX</b><br><b>F</b>   | <b>6. RACE</b><br><b>W</b> | <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>   |  | <b>8. DATE OF BIRTH</b><br><b>Sept. 10. 1906</b> |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Chief Operator.</b>  |                            | <b>10B. KIND OF BUSINESS OR INDUSTRY</b><br><b>C &amp; P Telephone Co.</b>  |  |  |
| <b>13. FATHER'S NAME</b><br><b>?</b>  |                            | <b>14. MOTHER'S MAIDEN NAME</b><br><b>?</b>   |  |  |
| <b>15. Was Deceased Ever in U. S. Armed Forces?</b><br>(Yes, no or unknown) (If yes, give war or dates of service)<br><b>-----</b>  |                            | <b>16. SOCIAL SECURITY NO.</b><br><b>212-03-6484</b>  |  |  |
| <b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br><b>157.9 I</b><br><b>CANCER of the PANCREAS 1 year</b><br><b>WITH LIVER METASTASIS.</b>  |                            | <b>CAUSE OF DEATH</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 year</b>  |  |  |
| <b>19A. DATE OF OPERATION</b><br><b>0</b>   |                            | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b><br><b>NO</b>  |  |  |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>   |                            | <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>NO</b>  |  |  |
| <b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)<br><b>(APPROX.)</b>  |                            | <b>21E. INJURY OCCURRED</b><br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  |  |
| <b>22. I certify that (I) (this hospital) attended the deceased from</b> <b>8-18 1969</b> <b>to</b> <b>10-29 1969</b><br><b>that (I) (we) lost saw the deceased alive on</b> <b>8-29 1969</b> <b>and that in (my) (our) opinion death occurred on the date</b><br><b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b> |                            | <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)   |  |  |
| <b>23A. SIGNATURE</b><br><b>Jorge Fuxa</b>  |                            | <b>23B. DATE SIGNED</b><br><b>10/29/69</b>  |  |  |
| <b>23C. PHYSICIAN'S NAME</b> (Type)<br><b>JORGE FUXA MD</b>   |                            | <b>23D. ADDRESS</b><br><b>2201 ARGONNE DR. BALTIMORE MD</b>   |  |  |
| <b>24A. BURIAL CREMATION, REMOVAL</b> (Specify)<br><b>Burial</b>  |                            | <b>24B. DATE</b><br><b>Nov. 3, 1969</b>   |  |  |
| <b>24C. NAME OF CEMETERY or CREMATORY</b><br><b>Balto. National</b>   |                            | <b>24D. LOCATION</b> (City, town, or county) (State)<br><b>Balto.</b>   |  |  |
| <b>25A. DATE REC'D BY HEALTH DEPT.</b><br><b>OCT 31 1969</b>  |                            | <b>25B. NAME OF REGISTRAR</b><br><b>Robert E. Chenoweth</b>   |  |  |
| <b>25C. FUNERAL DIRECTOR</b><br><b>Paul E. Chenoweth</b>  |                            | <b>ADDRESS</b><br><b>3615 Chestnut Ave.</b>   |  |  |

Monticello State Hospital  
3208 Chestnut St.  
Philadelphia, Pa.

Monticello State Hospital

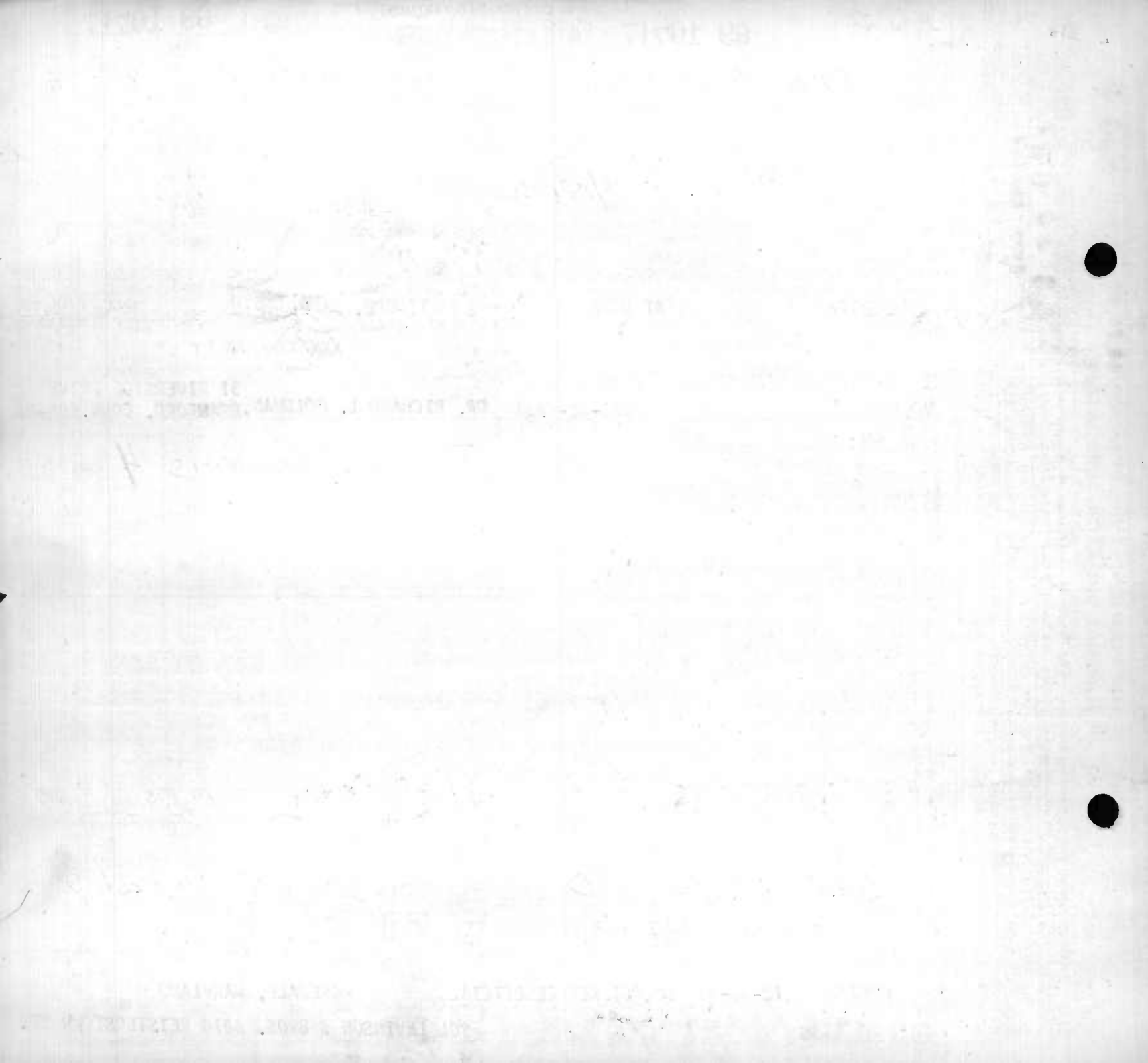
Center of the Hospital  
with other buildings

James F. Fox, M.D.  
10-21-21  
11-18-21  
12-24-21

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                  |   |                             |  |  |  |  |
|---|------------------|---|-----------------------------|--|--|--|--|
| G-435   |                  | 69 10717  |                             | BALTIMORE CITY HEALTH DEPARTMENT   |  | REG. NO. 69 10717  |  |
| BIRTH NO.   |                  | 1. NAME OF DECEASED<br>(Type or Print) ANNA M. GOLDMAN  |                             | 2. DATE AND HOUR OF DEATH<br>10/28/69 8 <sup>30</sup> A M.   |  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>33 JOHNS HOPKINS HOSPITAL  |                  |   |                             | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland<br>B. COUNTY Baltimore<br>C. CITY OR TOWN Baltimore<br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER 5909 Highgate Drive #15 |  |  |  |
| 5. SEX<br>Female  | 6. RACE<br>White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>7/04/10 | 9. AGE (In years last birthday)<br>59  | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Hours: Min.   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>HOUSEWIFE  |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>AT HOME  |                             | 11. BIRTHPLACE (State or foreign country)<br>BALTIMORE, MARYLAND   |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 13. FATHER'S NAME<br>Frank Cohen  |                  | 14. MOTHER'S MAIDEN NAME<br>Pauline <del>Oppenheimer</del> ?  |                             |  |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO  |                  | 16. SOCIAL SECURITY NO.<br>220-30-0538  |                             | 17. INFORMANT<br>ADDRESS 31 RIVERSIDE DRIVE<br>DR. RICHARD L. GOLDMAN, BRANFORD, CONN. #06405  |  |  |  |
| 18. CAUSE OF DEATH<br>320.1 I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)<br>PNEUMOCOCCAL MENINGITIS<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. |                  |   |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 DAYS   |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |                  |   |                             |  |  |  |  |
| 19A. DATE OF OPERATION<br>2   |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                             | 20A. AUTOPSY? (Yes or No)<br>Yes   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>NO |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                             | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                             | 21F. HOW DID INJURY OCCUR?   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 10/26 1969 to 10/28 1969, that (I) (we) last saw the deceased alive on 10/28 1969 and that (my) (aur) apinian death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                  |   |                             |  |  |  |  |
| 23A. SIGNATURE<br>Robert S. Weinberg MD.  |                  |   |                             | 23B. DATE SIGNED<br>10/28/69   |  | 23C. PHYSICIAN'S NAME (Type)<br>ROBERT S. WEINBERG                         |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>BURIAL  |                  | 24B. DATE<br>10-30-69   |                             | 24C. NAME OF CEMETERY or CREMATORY<br>BOBROISKER BENEFICIAL  |  | 24D. LOCATION (City, town, or county) (State)<br>ROSEDALE, MARYLAND        |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>OCT 31 1969  |                  | 25B. NAME OF REGISTRAR<br>Robert E. Fisher, M.D.  |                             | 25C. FUNERAL DIRECTOR<br>SOL LEVINSON & BROS. 6010 REISTERSTOWN RD.  |  | ADDRESS  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|---|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT  |   | REG. NO. <b>69 10718</b>  |  |
| L-523   |   | 69 10718  |  |
| BIRTH NO.   |   | CERTIFICATE OF DEATH  |  |
| 1. NAME OF DECEASED<br>(Type or Print)  |   | 2. DATE AND HOUR OF DEATH   |  |
| LANGGUTH, CARRIE LENA   |   | OCTOBER 30, 1969 9:45 A.M.  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><br><b>40 ST AGNES HOSPITAL</b>   |   | A. STATE<br><b>MARYLAND</b>   |  |
|   |   | B. COUNTY<br><b>BALTIMORE</b>   |  |
|   |   | C. CITY OR TOWN<br><b>BALTIMORE</b>   |  |
| D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | E. STREET AND NUMBER<br><b>905 ELMRIDGE AVE</b>   |  |
| 5. SEX<br><b>FEMALE</b>   | 6. RACE<br><b>WHITE</b>                                 | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>04 21 10</b>  |
| 9. AGE (in years lost birthday)<br><b>59</b>  |   | 10. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>   |   | 10B. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  |  |
| 13. FATHER'S NAME<br><b>JULIUS GOTTSCHALK</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>ELIZABETH BOYLE</b>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |   | 16. SOCIAL SECURITY NO.<br><b>217-01-8570</b>   |  |
| 17. INFORMANT<br><b>Mr. Alfred Langguth 905 Elmridge Ave. Arbutus</b>   |   | ADDRESS<br><b>ST AGNES RECORDS-BALTO MD 21229</b>   |  |
| 18. CAUSE OF DEATH<br><b>430.9 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><b>Subarachnoid Hemorrhage</b><br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) DUE TO, OR AS A CONSEQUENCE OF:<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 19A. DATE OF OPERATION<br><b>0</b>  |   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20A. AUTOPSY? (Yes or No)<br><b>NO</b>  |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)   |  |
| 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |   | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX.)  |  |
| 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |   | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that <b>XX</b> (this hospital) attended the deceased from <b>OCTOBER 29</b> 19 <b>69</b> to <b>OCTOBER 30</b> 19 <b>69</b> that <b>X</b> (we) last saw the deceased alive on <b>OCTOBER 30</b> 19 <b>69</b> and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>X</b> (We) (did) (did not) view the body after death.  |   |   |  |
| 23A. SIGNATURE<br><b>Charles J. Lancelotta M.D.</b>   |   | 23B. DATE SIGNED<br><b>10 30 69</b>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>CHARLES J LANCELOTTA M.D.</b>  |   | 23D. ADDRESS<br><b>ST AGNES HOSPITAL-CATON &amp; WILKENS AVE</b>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 24B. DATE<br><b>11-3-69</b>                             | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Memorial Park</b>  | 24D. LOCATION (City, town, or county) (State)<br><b>Dorsey Howard Maryland</b> |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 31 1969</b>   | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher, M.D.</b> | 25C. FUNERAL DIRECTOR<br><b>Howard H. Hubbard 4107 Wilkens Ave. 21229</b>   |  |

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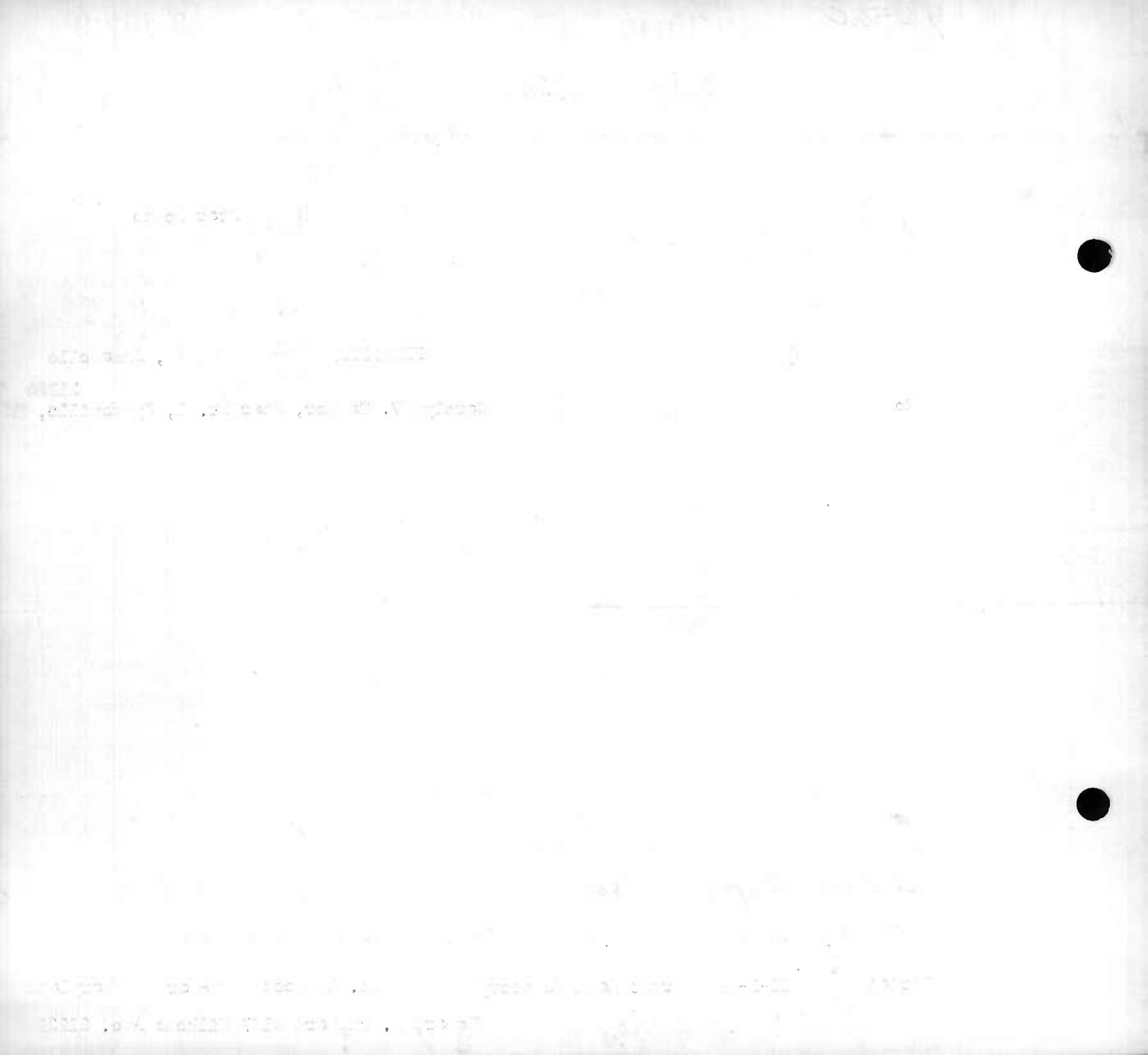
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                      |  |  |  |   |  |  |   |  |
|--|----------------------|--|--|--|---|--|--|---|--|
| T-560  |                      | 69 10719   |  | BALTIMORE CITY HEALTH DEPARTMENT   |   | X  |  | REG. NO. 69 10719                           |  |
| BIRTH NO.  |                      | 1. NAME OF DECEASED<br>(Type or Print) <b>WILLIAM B. TANNER SR</b>   |  |  |   | 2. DATE AND HOUR OF DEATH<br><b>10/30/69 7:00 A.M.</b>   |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br><b>Church Home &amp; Hospital</b>  |                      |  |  |  |   | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>Carroll Co</b> C. CITY OR TOWN <b>Sykesville</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Church Home &amp; Hospital</b>   |                      |  |  |  |   | E. STREET AND NUMBER <b>R.F.D. #1 Star Route</b>   |  |   |  |
| 5. SEX <b>M</b>  | 6. RACE <b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>2/19/08</b>  | 9. AGE (in years last birthday) <b>67</b> | If Under 1 Yr. Manths: Days: Hours: Min.   |  |   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>G. &amp; E. Co. Employee</b>   |                      |  |  | 10B. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)<br><b>U.S. (MD.)</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b> |  |
| 13. FATHER'S NAME<br><b>Charles B. Tanner</b>  |                      |  |  | 14. MOTHER'S MAIDEN NAME<br><b>XXXXXXX Canoll, Annabelle</b>             |   |  |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                      |  |  | 16. SOCIAL SECURITY NO.<br><b>212 057421</b>                             |   | 17. INFORMANT<br><b>Carolyn V. Tanner, Star Rt. 1, Sykesville, Md</b>  |  |   |  |
| 18. <b>258.9 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |                      |  |  |  |   | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br><b>Coronoid Syndrome</b><br><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><br><b>4 mos.</b><br><br>(C).....   |  |   |  |
| 19A. DATE OF OPERATION<br><b>2</b>   |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>            |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |   |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)  |                      | 21B. PLACE OF INJURY (e.g., in or about home, lam, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |  |  |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                      | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?   |   |  |  |   |  |
| 22. I certify that <del>if</del> (this hospital) attended the deceased from <b>10/26</b> 19 <b>69</b> to <b>10/30</b> 19 <b>69</b> that <del>if</del> (we) last saw the deceased alive on <b>10/30</b> 19 <b>69</b> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>if</del> (We) (did) <del>the</del> view the body after death.   |                      |  |  |  |   |  |  |   |  |
| 23A. SIGNATURE<br><b>Cezar A. Lopez MD</b>   |                      |  |  |  |   | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>  |  | 23B. DATE SIGNED<br><b>OCT. 30, 1969</b>    |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>CEZAR A. LOPEZ MD</b>   |                      |  |  |  |   | 23D. ADDRESS<br><b>CHURCH HOME AND HOSP.</b>   |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                      | 24B. DATE<br><b>11-3-69</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Crest Lawn Cemetery</b>         |   | 24D. LOCATION (City, town, or county) (State)<br><b>Rt. 40 West Howard Maryland</b>  |  |   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 31 1969</b>  |                      | 25B. NAME OF REGISTRAR<br><b>Reuben E. Taylor, MD.</b>   |  | 25C. FUNERAL DIRECTOR<br><b>Howard H. Hubbard</b>                        |   | ADDRESS<br><b>4107 Wilkens Ave. 21229</b>  |  |   |  |

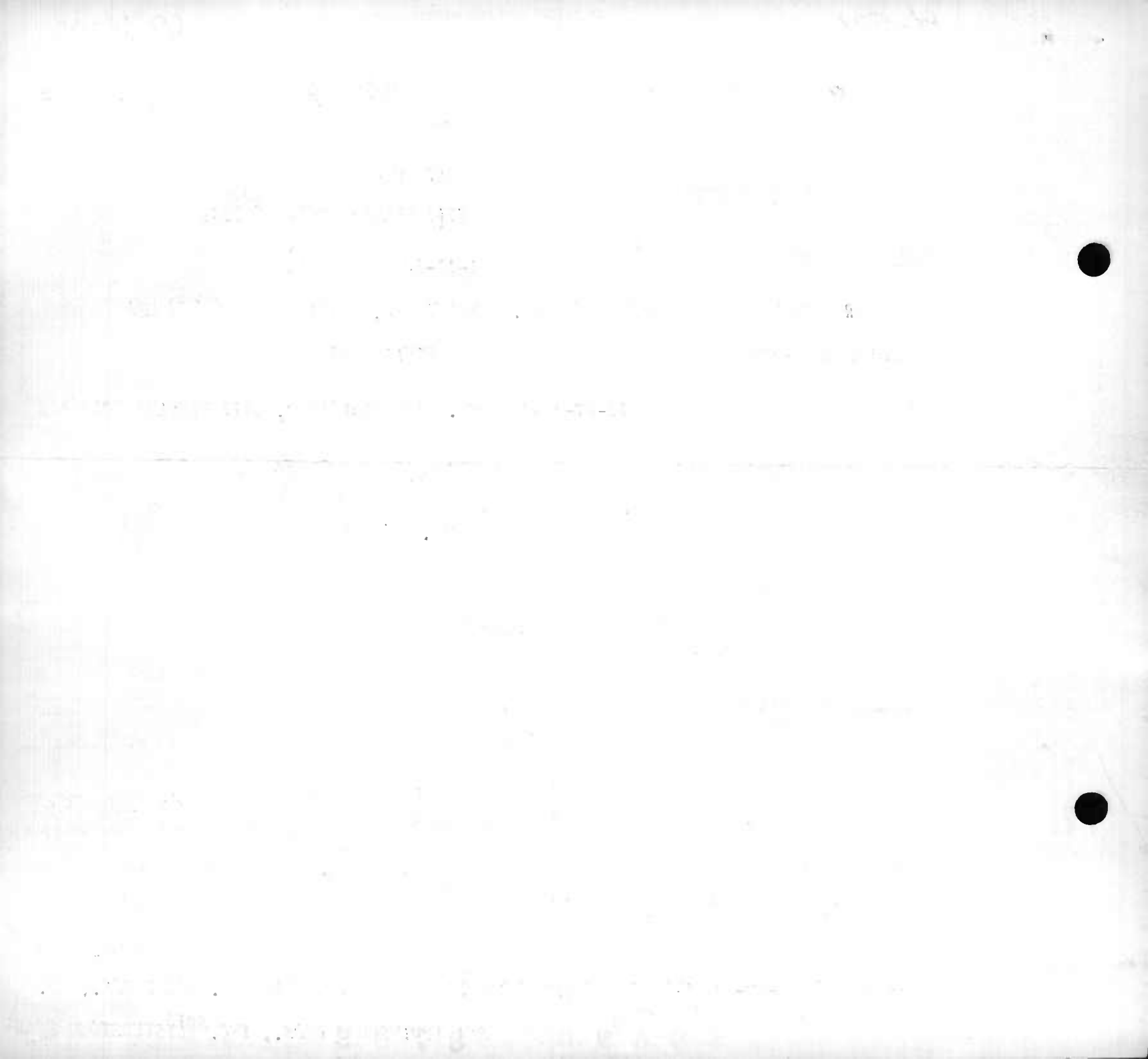




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

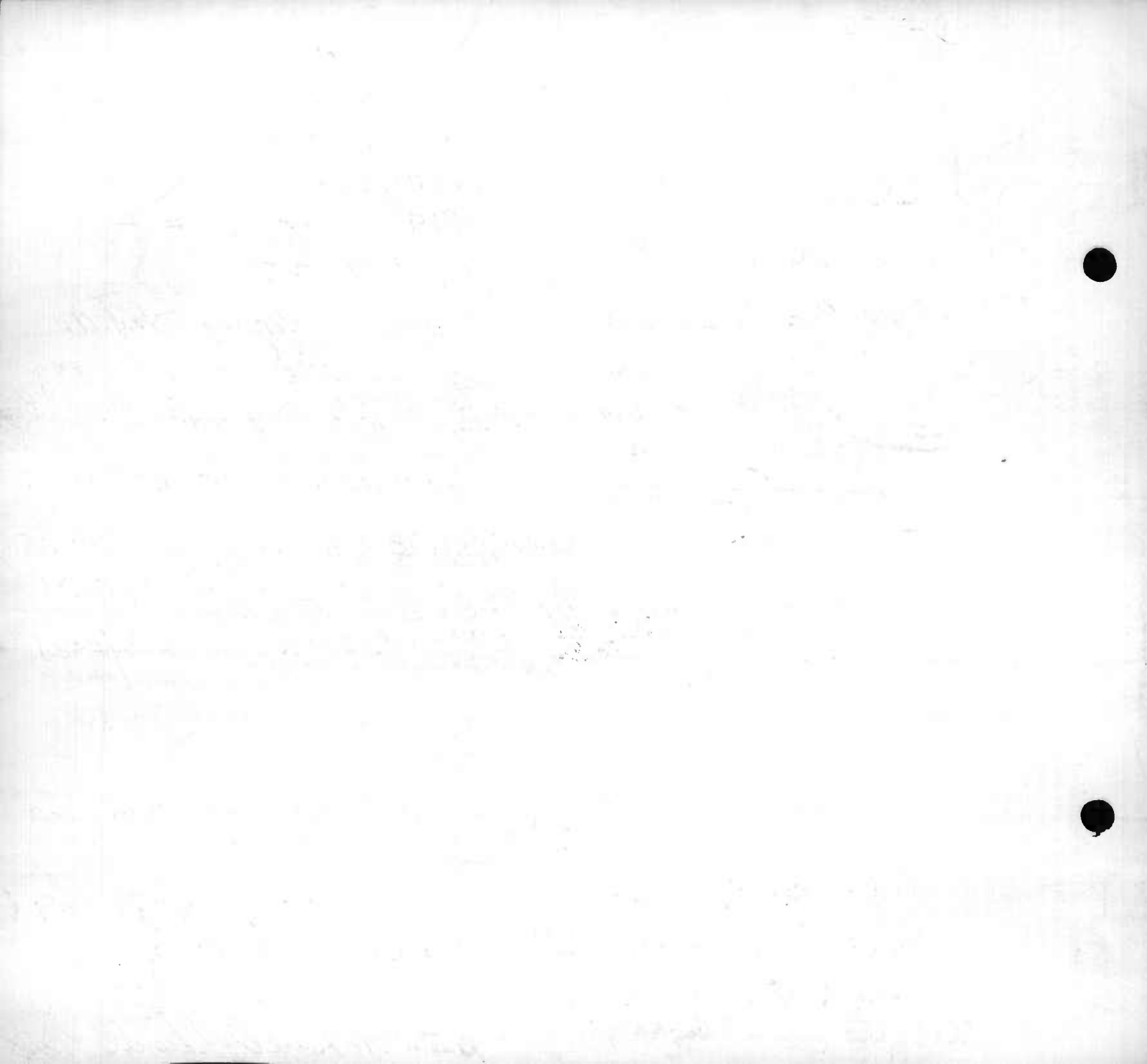
| BALTIMORE CITY HEALTH DEPARTMENT  |  |   |   | REG. NO. <span style="font-size: 2em;">69 10720</span>  |  |
|---|--|---|---|---|--|
| <b>BIRTH NO.</b><br><span style="font-size: 2em;">H-521</span>  |  | <span style="font-size: 2em;">69 10720</span>   |   | <b>CERTIFICATE OF DEATH</b>   |  |
| <b>1. NAME OF DECEASED</b><br><small>(Type or Print)</small><br><span style="font-size: 1.5em;">HONKOFSKY, JEROME</span>  |  |   | <b>2. DATE AND HOUR OF DEATH</b><br><span style="font-size: 1.5em;">10/28/69 1630 A.M.</span>   |   |  |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><br><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> <span style="margin-left: 20px;">(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</span><br><br><span style="font-size: 2em;">42 SINAI HOSPITAL</span>   |  |   | <b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission)<br><b>A. STATE</b> <span style="margin-left: 20px;">B. COUNTY</span><br><span style="font-size: 1.5em;">MARYLAND Baltimore 53-00</span><br><br><b>C. CITY OR TOWN</b> <span style="margin-left: 20px;">D. INSIDE CITY LIMITS?</span><br><span style="font-size: 1.5em;">BALTIMORE</span> <span style="margin-left: 20px;">YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></span><br><br><b>E. STREET AND NUMBER</b><br><span style="font-size: 1.5em;">3711 PINELEA ROAD #21208</span> |   |  |
| <b>5. SEX</b><br><span style="font-size: 1.5em;">MALE</span>  |  | <b>6. RACE</b><br><span style="font-size: 1.5em;">WHITE</span>  |   | <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> |  |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><span style="font-size: 1.5em;">PHARMACIST</span>   |  | <b>10B. KIND OF BUSINESS OR INDUSTRY</b><br><span style="font-size: 1.5em;">READS DRUG CO.</span>   |   | <b>8. DATE OF BIRTH</b><br><span style="font-size: 1.5em;">1-11-14</span>   |  |
| <b>13. FATHER'S NAME</b><br><span style="font-size: 1.5em;">NATHAN HONKOFSKY</span>   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><span style="font-size: 1.5em;">ETHEL CHAIGHT</span>   |   | <b>9. AGE</b> (In years last birthday)<br><span style="font-size: 1.5em;">55</span>   |  |
| <b>15. Was Deceased Ever in U. S. Armed Forces?</b><br><small>(Yes, no or unknown) (If yes, give war or dates of service)</small><br><span style="font-size: 1.5em;">NO</span>  |  | <b>16. SOCIAL SECURITY NO.</b><br><span style="font-size: 1.5em;">212-07-8144</span>  |   | <b>17. INFORMANT</b> <span style="margin-left: 20px;">ADDRESS</span><br><span style="font-size: 1.5em;">MRS. MARY HONKOFSKY, 3711 PINELEA ROAD #08</span>                               |  |
| <b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br><small>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</small><br><span style="font-size: 1.5em;">410.9 I</span>  |  | <b>CAUSE OF DEATH</b><br><b>(A) IMMEDIATE CAUSE</b><br><span style="font-size: 1.5em;">Coronary Occ</span><br><b>DUE TO, OR AS A CONSEQUENCE OF:</b><br><br><b>(B) ASCVD</b><br><b>DUE TO, OR AS A CONSEQUENCE OF:</b><br><br><b>(C)</b>  |   | <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>   |  |
| <b>II</b>   |  |   |   |   |  |
| <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>   |  |   |   |   |  |
| <b>19A. DATE OF OPERATION</b><br><span style="font-size: 1.5em;">10-28-69</span>  |  | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>   |   | <b>20A. AUTOPSY?</b> (Yes or No)<br><span style="font-size: 1.5em;">No</span>   |  |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)<br><input type="checkbox"/>  |  | <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><span style="font-size: 1.5em;">At Work</span>   |   | <b>21C. WHERE DID INJURY OCCUR?</b> <span style="margin-left: 20px;">(If in Baltimore City, give exact location)</span><br><span style="font-size: 1.5em;">At Work</span>               |  |
| <b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)<br><span style="font-size: 1.5em;">(APPROX.)</span>  |  | <b>21E. INJURY OCCURRED</b><br><b>While At Work</b> <input type="checkbox"/> <b>Not While At Work</b> <input type="checkbox"/>  |   | <b>21F. HOW DID INJURY OCCUR?</b>   |  |
| <b>22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.5em;">8</span> 19 <span style="font-size: 1.5em;">69</span> to <span style="font-size: 1.5em;">10-28</span> 19 <span style="font-size: 1.5em;">69</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.5em;">10-28</span> 19 <span style="font-size: 1.5em;">69</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.</b> |  |   |   |   |  |
| <b>23A. SIGNATURE</b><br><span style="font-size: 1.5em;">Jerome J. Poller M.D.</span>   |  |   |   | <b>23B. DATE SIGNED</b><br><span style="font-size: 1.5em;">10-28-69</span>  |  |
| <b>23C. PHYSICIAN'S NAME</b> (Type)<br><span style="font-size: 1.5em;">Jerome J. Poller M.D.</span>   |  |   |   | <b>23D. ADDRESS</b><br><span style="font-size: 1.5em;">2217 South Rd Balti 21209 Md</span>  |  |
| <b>24A. BURIAL CREMATION, REMOVAL</b> (Specify)<br><span style="font-size: 1.5em;">BURIAL</span>  |  | <b>24B. DATE</b><br><span style="font-size: 1.5em;">10-29-69</span>   |   | <b>24C. NAME OF CEMETERY OR CREMATORY</b><br><span style="font-size: 1.5em;">BETH ISAAC ADATH ISRAEL</span>   |  |
| <b>24D. LOCATION</b> (City, town, or county) (State)<br><span style="font-size: 1.5em;">GERMAN HILL &amp; N. POINT RDS., MD.</span>   |  | <b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="margin-left: 20px;">25B. NAME OF REGISTRAR</span> <span style="margin-left: 20px;">25C. FUNERAL DIRECTOR</span> <span style="margin-left: 20px;">ADDRESS</span><br><span style="font-size: 1.5em;">OCT 31 1969</span> <span style="font-size: 1.5em;">Sol Levinson</span> <span style="font-size: 1.5em;">SOL LEVINSON &amp; BROS., INC.</span> <span style="font-size: 1.5em;">6010 REISTERSTOWN ROAD</span> |   |   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| D-652  |  | 69 10721                                  |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | X REG. NO. 69 10721   |  |
| BIRTH NO.  |  |   |  | 1. NAME OF DECEASED<br>(Type or Print) <b>DI ERINGER CARL</b>   |  |   |  |
| 2. DATE AND HOUR OF DEATH<br><b>10-26-69 11 05 P M.</b>  |  |   |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>42 Sinai Hospital</b>   |  |   |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |  |   |  |
| 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO.</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  | E. STREET AND NUMBER <b>3819 Cedar Dr #7</b>  |  |   |  |
| 5. SEX <b>male</b>   |  | 6. RACE <b>white</b>                      |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>5-27-94</b>   |  |
| 9. AGE (In years last birthday) <b>75</b>  |  | 10. UNDER 1 Yr. Months: Days: Hours: Min. |  | 11. BIRTHPLACE (State or foreign country) <b>Germany</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Under-Car</b>   |  |   |  | 10B. KIND OF BUSINESS OR INDUSTRY <b>Hylers, Hochschild, Kausch, Singer, Herman</b>   |  |   |  |
| 13. FATHER'S NAME <b>Peter Dieringer</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME <b>Emma Hockel</b>   |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No None</b>  |  |   |  | 16. SOCIAL SECURITY NO. <b>213-01-8115</b>  |  | 17. INFORMANT <b>Ms. Rosalia P. Dieringer</b> ADDRESS <b>Baltimore Md. 3819 Cedar</b> |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>412.41</b>  |  |   |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>PULMONARY EDEMA HOURS</b>  |  |   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b>  |  |   |  | (B) CONGESTIVE HEART FAIL DUE TO, OR AS A CONSEQUENCE OF: <b>URE HOURS</b>  |  |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |  |   |  | (C) ARTERIOSCLECTIC CARDIO VASCULAR DISEASE <b>4 YEARS</b>  |  |   |  |
| 19A. DATE OF OPERATION <b>0</b>  |  |   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  |   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  |   |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10-16</b> 19 <b>69</b> to <b>10-26</b> 19 <b>69</b> that (I) (we) last saw the deceased alive on <b>10-26</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |   |  |   |  |   |  |
| 23A. SIGNATURE <b>W. M. Dieringer MD</b>   |  |   |  | 23B. DATE SIGNED <b>10-26-69</b>  |  | 23C. PHYSICIAN'S NAME (Type) <b>RUBEN DRZANUSKI MD</b>                                |  |
| 24A. BURIAL CREMATION REMOVAL (Specify)  |  |   |  | 24B. DATE   |  | 24C. NAME OF CEMETERY OR CREMATORY <b>St. Vincent's Cemetery</b>                      |  |
| 24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>   |  |   |  | 25A. DATE REC'D BY HEALTH DEPT. <b>OCT 31 1969</b>  |  |   |  |
| 25B. NAME OF REGISTRAR <b>James E. Taylor</b>  |  |   |  | 25C. FUNERAL DIRECTOR <b>James E. Taylor</b> ADDRESS <b>Baltimore Md.</b>   |  |   |  |



**B-240** 69 10722 BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** REG. NO. **69 10722**

|  |                         |  |  |  |  |   |  |
|--|-------------------------|--|--|--|--|---|--|
| BIRTH NO. <b>69-18919</b>  |                         | 1. NAME OF DECEASED<br>(Type or Print) <b>Keith Russell</b>  |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Estimated <input type="checkbox"/>  |  | Month Day Year Hour<br>M.   |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Sinai Hospital (DOA)</b>  |                         | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>10 26 69 6:25 P.M.</b>  |  | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> |  | C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 6. SEX<br><b>Male</b>  | 7. RACE<br><b>White</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. DATE OF BIRTH<br><b>Oct 15, 1969</b>  |  | 10. AGE (In years last birthday)<br><b>12</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore</b>  |                         | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 13. FATHER'S NAME<br><b>Michael W. Russell</b>   |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Child</b>                  |  |
| 15. MOTHER'S MAIDEN NAME<br><b>Francine Levine</b>   |                         | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, name unknown) (If yes, give war or dates of service)   |  | 17. SOCIAL SECURITY NO.  |  | 18. INFORMANT ADDRESS<br><b>Mr. Michael W. Russell, 8402 Liberty</b>  |  |
| 19. <b>746.91</b>  |                         | CAUSE OF DEATH   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) |                         | (A) IMMEDIATE CAUSE <b>Congenital heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF:   |  |  |  |   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |                         | (B) _____<br>DUE TO, OR AS A CONSEQUENCE OF:   |  |  |  |   |  |
| (C) _____  |                         |  |  |  |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |                         |  |  |  |  |   |  |
| 20A. DATE OF OPERATION   |                         | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 21. AUTOPSY? (Yes or No)<br><b>yes</b>   |  |   |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                         | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?   |  |   |  |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                         | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 22F. HOW DID INJURY OCCUR?   |  |   |  |
| 23.  |                         | I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  | DATE SIGNED   |  |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>   |                         | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>  |  | <b>10-27-69</b>   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |                         | 24B. DATE <b>Oct 27, 1969</b>  |  | 24C. NAME OF CEMETERY or CREMATORY <b>St. Olive Cemetery</b>   |  | 24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>   |  |
| 25A. DATE REC'D BY HEALTH DEPT. <b>OCT 31 1969</b>   |                         | 25B. NAME OF REGISTRAR <b>Frank J. Newell</b>  |  | 25C. FUNERAL DIRECTOR <b>St. Louis</b>   |  | ADDRESS   |  |

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VALLEY COUNTY  
VALLEY COUNTY  
VALLEY COUNTY

10/10/55

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 10723

BIRTH NO.

|   |                         |  |  |  |  |   |  |
|---|-------------------------|--|--|--|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>CONRAD KOUNS</b>   |                         |  |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> 10 25 69 3:40 p M.   |  |   |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(If not in hospital or institution, give street address or location)<br><b>Church Home &amp; Hospital D.O.A.</b>  |                         |  |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>Oct. 25, 1969 3:40 p M.</b>   |  |   |  |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>103</b>  |                         |  |  |  |  |   |  |
| 6. SEX<br><b>Male</b>   | 7. RACE<br><b>White</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | C. CITY OR TOWN<br><b>Balto.</b>   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 9. DATE OF BIRTH<br><b>2-6-1910</b>   |                         | 10. AGE (In years last birthday)<br><b>59</b>  |  | E. STREET AND NUMBER<br><b>2610 Fleet St.</b>  |  |   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>KY.</b>   |                         | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 13. FATHER'S NAME<br><b>? KOUNS</b>  |  |   |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>ELECTRICIAN</b>   |                         | 14B. KIND OF BUSINESS OR INDUSTRY<br><b>BETH. STEEL</b>  |  | 15. MOTHER'S MAIDEN NAME<br><b>MRS. KATHERINE ?</b>  |  |   |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>  |                         | 17. SOCIAL SECURITY NO.  |  | 18. INFORMANT ADDRESS<br><b>MR. EUGENE MOLKAU 525 N. LINWOOD AVE</b>   |  |   |  |
| 19. <b>412.4</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |                         |  |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) _____<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) _____ |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                         |  |  |  |  |   |  |
| 20A. DATE OF OPERATION<br><b>2</b>  |                         | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 21. AUTOPSY? (Yes or No)<br><b>YES</b>  |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                         | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?   |  |   |  |
| 22D. TIME OF INJURY (Approx.)<br>(Month) (Day) (Year) (Hour)  |                         | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 22F. HOW DID INJURY OCCUR?   |  |   |  |
| 23.<br>I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br><br>ACTUAL SIGNATURE <b>Isidore Mihalakis, M.D.</b> M.D.<br>EXAMINER'S NAME (Type)<br><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED <b>10/26/69</b> |                         |  |  |  |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 24B. DATE<br><b>10/29/69</b>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Oakland Cemetery</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore Maryland</b>                    |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 31 1969</b>   |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>  |  | 25C. FUNERAL DIRECTOR<br><b>RAYMOND L. KACZOROWSKI</b>   |  | ADDRESS<br><b>2525 FLEET ST.</b>  |  |

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Estimated from Steel

max. 1000000

Mr. Lucius Nelson, Esq. Chicago

410.4

WILLIAM L. BROWN

WILLIAM L. BROWN

Wm. L. Brown, Esq. Chicago  
Wm. L. Brown, Esq. Chicago



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

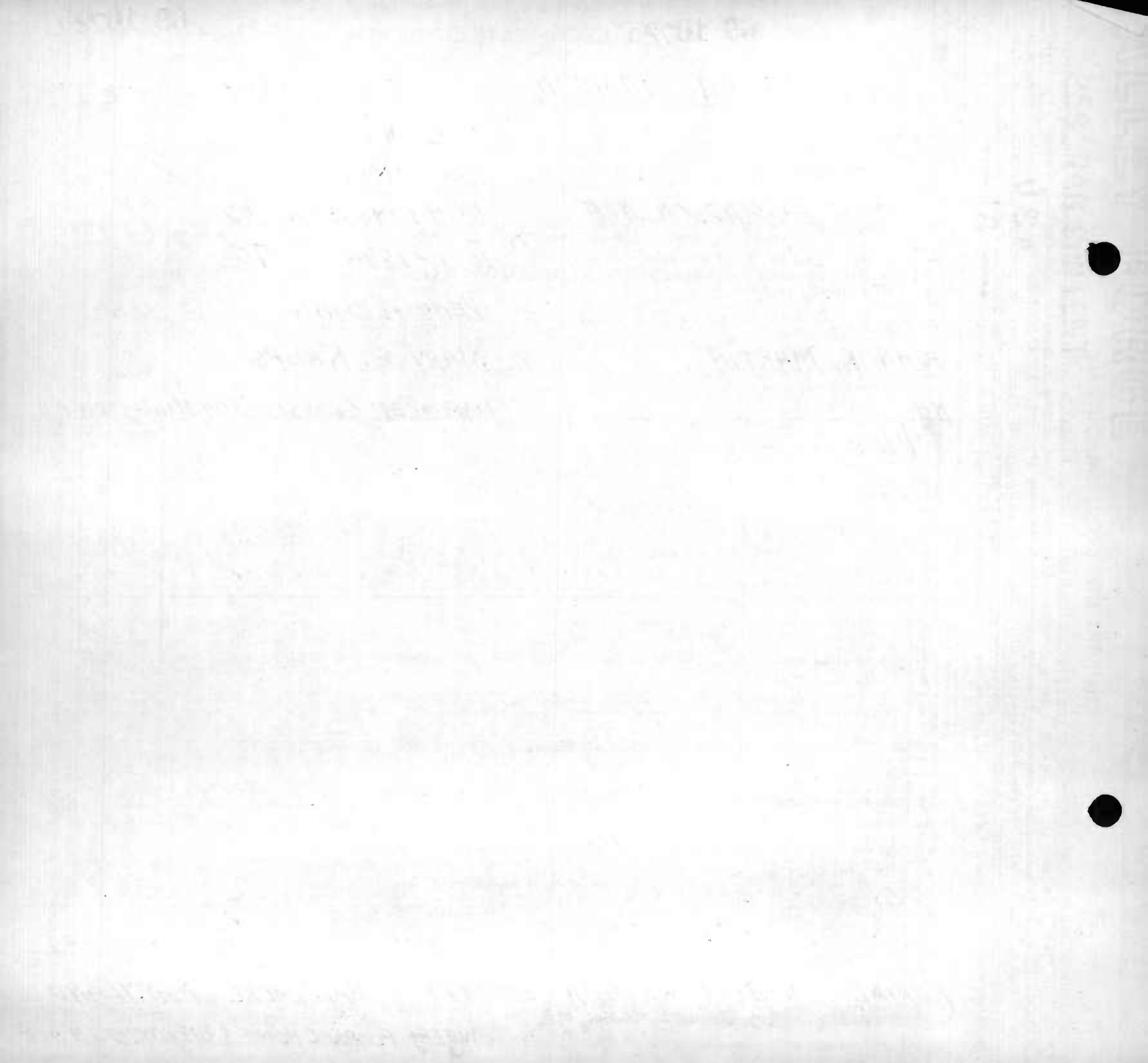
| H-120 69 10724  |  |   |  | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH   |  | REG. NO. 69 10724   |  |
|---|--|---|--|--|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Ruth M Haavig</b>   |  |   |  | 2. DATE AND HOUR OF DEATH<br><b>10/29/69</b> <b>9:01 A.M.</b>  |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>949 Jeffrey St<br/>Baltimore, Md 21225</b>  |  |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md</b><br>B. COUNTY <b>2544</b> |  |   |  |
| 5. SEX <b>Female</b>  |  |   |  | 6. RACE <b>White</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  |   |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 8. DATE OF BIRTH <b>2/8/02</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Norway</b>  |  |   |  | 9. AGE (In years last birthday) <b>67</b>  |  | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |  | 13. FATHER'S NAME<br><b>Harry Fields</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Unk</b>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  |   |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><b>Oscar M Haavig 949 Jeffrey St 21225</b>   |  |
| 18. <b>412.31</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b><br>(A) IMMEDIATE CAUSE<br><b>Coronary heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <b>arterio-sclerotic heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____ |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |   |  |  |  |   |  |
| 19A. DATE OF OPERATION  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)          |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |  | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>7/28/69</b> 19 to <b>10/29/69</b> 19<br>that (I) (we) last saw the deceased alive on <b>10/27/69</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |  |   |  |  |  |   |  |
| 23A. SIGNATURE<br><b>[Signature]</b>  |  |   |  | 23B. DATE SIGNED<br><b>10/29/69</b>  |  | 23C. PHYSICIAN'S NAME (Type)<br><b>Ricardo Lopez</b>  |  |
| 23D. ADDRESS<br><b>1228 S. Charles St. Balto. Md 21230</b>  |  |   |  | 23E. FUNERAL DIRECTOR<br><b>McGilly H. 237 Patapsco Ave</b>  |  | 23F. ADDRESS<br><b>21275</b>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 24B. DATE<br><b>10/31/69</b>  |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Lake View Mem Pk</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Liberty Rd Balto Md</b>   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 3 1969</b>  |  | 25B. NAME OF REGISTRAR<br><b>[Signature]</b>  |  | 25C. FUNERAL DIRECTOR<br><b>McGilly H. 237 Patapsco Ave</b>  |  | 25D. ADDRESS<br><b>21275</b>  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |                     |   |  | REG. NO. 69 10725  |   |
|--|---------------------|---|--|--|---|
| BIRTH NO. 69 10725   |                     |   |  |  |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>ANN ELLEN MARTIN</b>   |                     |   | 2. DATE AND HOUR OF DEATH<br><b>OCT. 31, 1969</b> <b>5:20</b> A.M.   |  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                     |   | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>BALTIMORE</b>                                      |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>HOOD CONVALESCENT HOME</b><br><b>90 5313 EDMONDSON AVE</b>  |                     |   | C. CITY OR TOWN<br><b>BALTIMORE</b>  |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX<br><b>F</b>   | 6. RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10-1-1894</b>   | 9. AGE (In years last birthday)<br><b>75</b>                             | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                     | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>PENNSYLVANIA</b>         |   |
| 13. FATHER'S NAME<br><b>JOHN R. MARTIN</b>   |                     |   | 14. MOTHER'S MAIDEN NAME<br><b>MARY E. KREPS</b>   |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>  |                     | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><b>MARGARET GLAESER 504 KINGSTON RD</b>                 |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><b>412.2 I</b><br>(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)   |                     |   | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>Myocardial Ischemia</b><br><b>1 mo.</b>  |  |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                     |   | (B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>marked cardiac hypertrophy</b><br><b>1 yr.</b><br>(C) DUE TO, OR AS A CONSEQUENCE OF:<br><b>Hypertension C.V. Disease</b><br><b>15 yr.</b> |  |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |                     |   |  |  |   |
| 19A. DATE OF OPERATION<br><b>0</b>   |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                     | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Feb. 15</b> 19 <b>67</b> to <b>OCT. 31</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>OCT. 27</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                     |   |  |  |   |
| 23A. SIGNATURE<br><b>Wilmer K. Gallagher, M.D.</b>   |                     |   |  | 23B. DATE SIGNED<br><b>10-31-69</b>                                      |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Wilmer K. Gallagher, M.D.</b>   |                     |   |  | 23D. ADDRESS<br><b>6209 Frederick Ave., Baltimore, Md. 21228</b>         |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                     | 24B. DATE<br><b>11-3-69</b>   |  | 24C. NAME of CEMETERY or CREMATORY<br><b>WESTERN CEMETERY</b>            |   |
| 24D. LOCATION<br><b>BALTIMORE MARYLAND</b>   |                     | 25A. DATE RECEIVED BY HEALTH DEPARTMENT<br><b>NOV 3 1969</b>  |  |  |   |
| 25B. NAME OF REGISTRAR<br><b>W. E. G. G. G.</b>  |                     | 25C. FUNERAL DIRECTOR<br><b>WEBER FUNERAL HOME 5311 EDMONDSON AVE</b>   |  |  |   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| 69 10726  |  | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH   |  | REG. NO. <u>299951</u><br><u>69 10726</u>   |
|---|--|--|--|---|
| BIRTH NO.   |  | 1. NAME OF DECEASED<br>(Type or Print) <u>CARTER JAMES</u>   |  | 2. DATE AND HOUR OF DEATH<br><u>11/1/69 at 6:05 AM</u> M.   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>MARYLAND</u> & COUNTY <u>2788</u> |  |   |
| 5. SEX <u>M</u>   |  | 6. RACE <u>Negro</u>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Kennelman</u>   |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Veterinarian</u>   |  | 8. DATE OF BIRTH<br><u>2/3/09</u>   |
| 13. FATHER'S NAME<br><u>James Carter</u>  |  | 14. MOTHER'S MAIDEN NAME<br><u>Maggie Hackley</u>  |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>Yes</u> <u>World War II</u>  |  | 16. SOCIAL SECURITY NO.<br><u>160 16 1892</u>  |  | 9. AGE (in years last birthday)<br><u>60 ym.</u>  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)<br><u>CAUSE OF DEATH</u><br><u>Bronchogenic Carcinoma - Metastases</u><br>(A) IMMEDIATE CAUSE <u>UREMIA</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <u>PNEUMONIA ? MALIGNANCY</u><br>DUE TO, OR AS A CONSEQUENCE OF: <u>BONES</u><br>(C) _____ |  | 11. BIRTHPLACE (State or foreign country)<br><u>Culpepper County, Va.</u>  |  |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  | 17. INFORMANT<br><u>Elise Carter</u>   |  |   |
| 19A. DATE OF OPERATION<br><u>2</u>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | ADDRESS<br><u>5400 Park Heights Ave.</u>  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examined) <input type="checkbox"/>  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>months</u>   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                              |  |   |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10/19/69</u> to <u>11/1/69</u> and that (I) (we) last saw the deceased alive on <u>11/1/69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |  | 20A. AUTOPSY? (Yes or No)<br><u>Yes</u>  |  |   |
| 23A. SIGNATURE<br><u>Kapoor</u> M.D.  |  | 23B. DATE SIGNED<br><u>11/1/69</u>   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>Dr. NEELAM KAPOOR M.D.</u>   |  | 23D. ADDRESS<br><u>Legis T. Gwynn 4517 Park Heights Ave.</u>   |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 24B. DATE<br><u>11/5/69</u>  |  | 24C. NAME OF CEMETERY or CREMATORY<br><u>Baltimore National Cem.</u>  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 3 1969</u>  |  | 25B. NAME OF REGISTRAR<br><u>Rafael E. Jackson M.D.</u>  |  | 25C. FUNERAL DIRECTOR<br><u>Legis T. Gwynn</u>  |

Amended cert. signed by Dr/Stanford H.Malinow of Sinai

## 69 10727 CERTIFICATE OF DEATH

REG. NO. 69 10727

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |   |  |
|--|--|---|--|
| BIRTH NO.  |  | BALTIMORE CITY HEALTH DEPARTMENT  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>TERRY, HAZEL V.</b>  |  | 2. DATE AND HOUR OF DEATH<br><b>10/29/69</b> <b>2:15</b> A.M.   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>BALTIMORE CITY HOSPITALS</b><br><b>4940 Eastern Ave.</b><br><b>Balto. Md. 21224</b>   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>1602</b><br>C. CITY OR TOWN <b>Baltimore</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>1515 Edmondson Ave. 21223 007</b> |  |
| 5. SEX<br><b>Female</b>  | 6. RACE<br><b>Negro</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>1-11-13</b>   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Homemaker</b>  |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>at home</b>   | 9. AGE (In years last birthday)<br><b>56</b>                                       |
| 11. BIRTHPLACE (State or foreign country)<br><b>Georgia</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Verdell Cawthon</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Phipps</b>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>  |  | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><b>BCH Records:</b>   |  | ADDRESS<br><b>4940 Eastern Ave. 21224</b>   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>250.9 I</b><br><b>ELECTROLYTE IMBALANCE</b>  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 WKS</b>  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |  | (B) <b>DIABETES</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Many years</b>   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>Congestive Heart Failure + Renal Failure</b>  |  |   |  |
| 19A. DATE OF OPERATION<br><b>2</b>   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20A. AUTOPSY? (Yes or No)<br><b>yes</b>   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>yes</b> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)             | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  | 21E. INJURY OCCURRED<br>While At <input type="checkbox"/> Nat While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Oct 16</b> 19 <b>69</b> to <b>Oct 29</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>Oct 28</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. |  |   |  |
| 23A. SIGNATURE<br><b>Dale N. Schumacher, M.D.</b>  |  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>   | 23B. DATE SIGNED<br><b>10/29/69</b>  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Dale N. Schumacher, M.D.</b>  |  | 23D. ADDRESS<br><b>Baltimore City Hospitals</b><br><b>4940 Eastern Ave. 21224</b>   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   | 24B. DATE<br><b>10/31/69</b>   | 24C. NAME OF CEMETERY or CREMATORY<br><b>Hospit A-maryland</b>  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore</b>                  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 3 1969</b>   | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor</b>  | 25C. FUNERAL DIRECTOR<br><b>Robert E. Taylor</b>  | ADDRESS<br><b>175 1/2 E. ...</b>   |





D-120

69 10728

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 10728

REG. NO.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print) **ELVIRA C. DAVIS**2. DATE  
OF  
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

**FRANKLIN SQUARE HOSPITAL (DOA)**3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

**November 1, 1969****12:48 A.M.**

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

**Maryland**

B. COUNTY

**1603**

6. SEX

**Female**

7. RACE

**Negro**8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

C. CITY OR TOWN

**Baltimore**

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

**Nov 24 1920**

10. AGE (In years most birthday)

**48**

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

**604 N. Gilmore Street**

11. BIRTHPLACE (State or foreign country)

**BALTO MD**

12. CITIZEN OF

**USA**

13. FATHER'S NAME

**JAMES A. BUTLER**

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**BAR MAID**

14B. KIND OF BUSINESS OR INDUSTRY

**CLUB**

15. MOTHER'S MAIDEN NAME

**HILDA LANGKORD**

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

**NO**

17. SOCIAL SECURITY NO.

**220-17-1004 HILDA BLOW**

18. INFORMANT

ADDRESS

**COVINGTON**

19.

**E 965 X**

CAUSE OF DEATH

**Gunshot wound of Abdomen**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

**yes**22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

**Home**

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

**2nd floor- 604 N. Gilmore Street**22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) **Nov. 1, 1969 12:10 A.M.**

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

**Shot during altercation with boyfriend**

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)**Ronald N. Kornblum, M.D.**CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

**11/1/69**

24A. BURIAL CREMATION, REMOVAL (Specify)

**Burial**

24B. DATE

**11/1/69**

24C. NAME OF CEMETERY or CREMATORY

**MT AUBURN**

24D. LOCATION (City, town, or county)

**BALTO MD**

(State)

25A. DATE REC'D BY HEALTH DEPT.

**NOV 3 1969**

25B. NAME OF REGISTRAR

**James E. Gable, M.D.**

25C. FUNERAL DIRECTOR

**Marshall P. Hays 6350 Gilman St.**

ADDRESS

ESTATE OF

DECEASED

2/1/77

WALTON

WALTON

WALTON

WALTON

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |                     |   |                             | Registered No.  |  |
|--|---------------------|---|-----------------------------|---|--|
| 69 10729   |                     | 69 10729  |                             |   |  |
| BIRTH NO.  |                     | 69 10729  |                             | BALTIMORE CITY HEALTH DEPARTMENT  |  |
| M.E. CASE NO.  |                     | 69 10729  |                             | BALTIMORE CITY HEALTH DEPARTMENT  |  |
| 1. NAME OF DECEASED<br>(Type or Print)   |                     | NANCY M. FULTON   |                             | 2. DATE AND HOUR OF DEATH<br>11/1/69 2:32 P.M.  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |                     | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE B. COUNTY<br>BALTIMORE MD. 1510 |                             | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br>3926 RIDGEWOOD AVE |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>3926 RIDGEWOOD AVE.<br>00  |                     | (If not in hospital or institution, give street address or location)  |                             | D. STREET ADDRESS (If rural, give location)   |  |
| 5. SEX<br>FEMALE   | 6. RACE<br>FILIPINO | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br>MARRIED   | 8. DATE OF BIRTH<br>11/9/31 | 9. AGE (In years lost birthday)<br>38   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>SEAMRESS |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>SEAMRESS  |                     | 10B. KIND OF BUSINESS OR INDUSTRY<br>SEWING SUPERVISOR  |                             | 11. BIRTHPLACE (State or foreign country)<br>PHILIPPINE ISLANDS                               |  |
| 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A  |                     | 13. FATHER'S NAME<br>NOT KNOWN  |                             | 14. MOTHER'S MAIDEN NAME<br>NOT KNOWN   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO   |                     | 16. SOCIAL SECURITY NO.<br>213-36-5200  |                             | 17. INFORMANT<br>JOSEPH FULTON-3926 RIDGEWOOD AVE.  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>203 X I  |                     | CAUSE OF DEATH<br>(A) Myeloma + Renal failure<br>(B) DUE TO<br>(C) DUE TO   |                             | INTERVAL BETWEEN ONSET AND DEATH  |  |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                     | II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.              |                             |   |  |
| 19A. DATE OF OPERATION   |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                             | 20A. AUTOPSY? (Yes or No)   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                             | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |  |
| 21D. TIME OF INJURY (APPROX.)  |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                         |                             | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from July 19 69 to 11-1 19 69, that (I) (we) lost saw the deceased alive on 11-1 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                     | 23A. SIGNATURE<br>Jerome J. Collier   |                             | 23B. DATE SIGNED<br>11-2-69   |  |
| 23C. PHYSICIAN'S NAME (Type)<br>Jerome J. Collier  |                     | 23D. ADDRESS<br>2217 South Rd Baltimore MD  |                             |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>BURIAL   |                     | 24B. DATE<br>11/5/69  |                             | 24C. NAME OF CEMETERY or CREMATORY<br>BALTO. NAT. CEM.  |  |
| 24D. LOCATION<br>BALTO, MD.  |                     | 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 3 1969   |                             | 25B. NAME OF REGISTRAR<br>Robert E. Taylor, M.D.  |  |
| 25C. FUNERAL DIRECTOR<br>MARGARET J. ROWEN   |                     | 25D. ADDRESS<br>3106 WILKESBORO AVE   |                             |   |  |

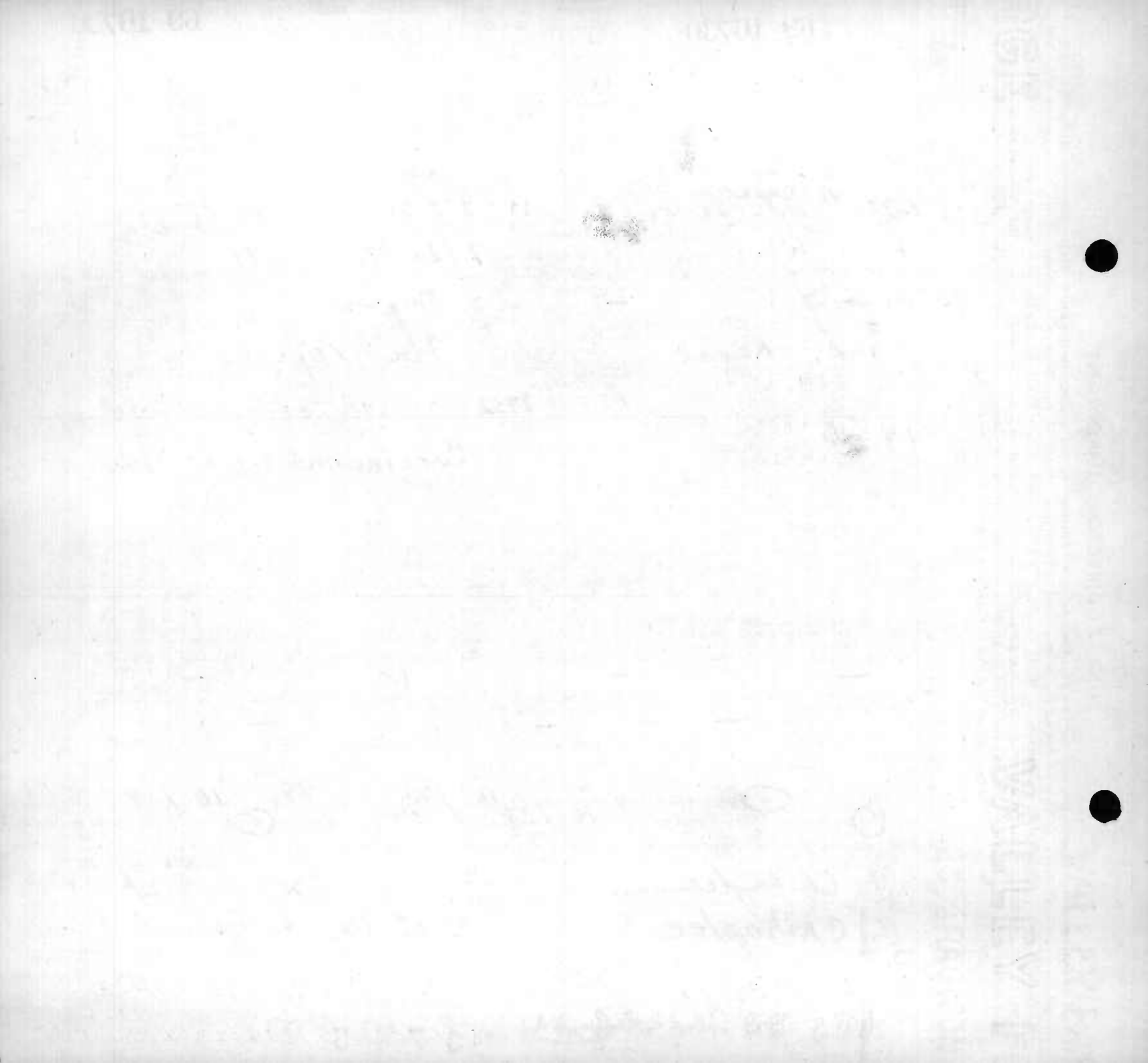
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |   |   |   | REG. NO. <b>69 10730</b>                                    |
|--|---|---|---|---|
| 69 10730   |   | CERTIFICATE OF DEATH  |   |   |
| BIRTH NO.  |   | 1. NAME OF DECEASED<br>(Type or Print) <i>Herman, Frances</i>   |   | 2. DATE AND HOUR OF DEATH<br><i>Oct. 28, 1969 5:45 P.M.</i> |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |   | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>                                    |   |   |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><i>49 North Charles General Hosp.<br/>2724 N. Charles St.<br/>Balt'o. Md - 21218</i>  |   | C. CITY OR TOWN<br><i>Baltimore</i>   | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
|  |   | E. STREET AND NUMBER<br><i>212 S. Madeira St.</i>   |   |   |
| 5. SEX<br><i>F</i>   | 6. RACE<br><i>W</i>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                     | 8. DATE OF BIRTH<br><i>7/28/98</i>  | 9. AGE (In years last birthday)<br><i>71</i>                |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>  |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>-</i>   | 11. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>                                  | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                  |
| 13. FATHER'S NAME<br><i>Frank Kurek</i>  |   | 14. MOTHER'S MAIDEN NAME<br><i>Jda Kopera</i>   |   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |   | 16. SOCIAL SECURITY NO.<br><i>055 16 8732</i>   | 17. INFORMANT<br><i>MR. JOHN HERMAN</i>   |   |
|  |   | ADDRESS<br><i>212 S. MADEIRA ST.</i>  |   |   |
| 18. <i>1950</i> I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |   | CAUSE OF DEATH<br><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><i>Carcinomatosis of abdomen 1x</i><br><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) _____ |   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |   |   |   |   |
| 19A. DATE OF OPERATION<br><i>0</i>   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>-</i>  | 20A. AUTOPSY? (Yes or No)<br><i>No</i>  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>-</i>         | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <i>-</i>   | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?  |   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <i>10/25</i> 19 <i>69</i> to <i>10/28</i> 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>10/28</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |   |   |   |   |
| 23A. SIGNATURE<br><i>V. Chitraplee</i>   |   |   | 23B. DATE SIGNED<br><i>Oct. 28, 69</i>  |   |
| 23C. PHYSICIAN'S NAME (Type)<br><i>V. Chitraplee</i>   |   |   | 23D. ADDRESS<br><i>North Charles General Hospital</i>   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>BURIAL</i>  | 24B. DATE<br><i>10/31/69</i>  | 24C. NAME of CEMETERY or CREMATORY<br><i>SACRED HEART Cem.</i>  | 24D. LOCATION (City, town, or county) (State)<br><i>BALTIMORE Md.</i>                         |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>NOV 3 1969</i>   | 25B. NAME OF REGISTRAR<br><i>John E. Taylor, Jr.</i>  | 25C. FUNERAL DIRECTOR<br><i>Raymond G. Kaczorowski</i>  | ADDRESS<br><i>2525 FLEET ST.</i>  |   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |  |  |  | REG. NO. <b>69 10731</b>   |  |
|---|--|--|--|--|--|
| BIRTH NO. <b>69 10731</b>   |  | CERTIFICATE OF DEATH   |  |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Alma L. Witold</b>  |  | 2. DATE AND HOUR OF DEATH<br><b>10/31/69</b>   |  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>702</b> |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>00</b>   |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>539 N. LUZERNE AVE</b>                                      |  | C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 5. SEX <b>FEMALE</b>  |  | 6. RACE <b>WHITE</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |
| 8. DATE OF BIRTH <b>3/6/95</b>  |  | 9. AGE (In years last birthday) <b>74</b>  |  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>   |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>  |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>  |  | 13. FATHER'S NAME <b>FRANKLIN P. STONG</b>   |  | 14. MOTHER'S MAIDEN NAME <b>ALICE M. LOMISON</b>   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>  |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS<br><b>MR. JACK WITOLD 539 N. LUZERNE</b>   |  |
| 18. <b>153.9 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>CARCINOMA - LGE. BOWEL</b> |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>59 YEARS</b>   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  | (B) DUE TO, OR AS A CONSEQUENCE OF:  |  | (C) DUE TO, OR AS A CONSEQUENCE OF:  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |  |  |  |  |
| 19A. DATE OF OPERATION <b>1964</b>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CRST. - BOWEL</b>  |  | 20A. AUTOPSY? (Yes or No) <b>NO</b>  |  |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                         |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  |
| 21F. HOW DID INJURY OCCUR?  |  | 22. I certify that (I) (this hospital) attended the deceased from <b>2/7/69</b> 19 to <b>10/31/69</b> 19                               |  | that (I) (we) last saw the deceased alive on <b>10/27/69</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |
| 23A. SIGNATURE <b>BENJ. B. MOSES, M.D.</b>  |  | 23B. DATE SIGNED <b>10/31/69</b>   |  | 23C. PHYSICIAN'S NAME (Type) <b>BENJ. B. MOSES, M.D.</b>   |  |
| 23D. ADDRESS <b>448 N. LUZERNE AVE. BALD. MD.</b>   |  | 24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |  | 24B. DATE <b>11/3/69</b>   |  |
| 24C. NAME OF CEMETERY OR CREMATORY <b>HOLY ROSARY CEM. BALTIMORE MD.</b>  |  | 24D. LOCATION (City, town, or county) (State)  |  | 25A. DATE REC'D BY HEALTH DEPT. <b>NOV 3 1969</b>  |  |
| 25B. NAME OF REGISTRAR <b>Robert E. Taylor, MD.</b>   |  | 25C. FUNERAL DIRECTOR <b>RAYMOND L. KACZOROWSKI</b>  |  | 25D. ADDRESS <b>2525 FLEET ST.</b>   |  |



10-10-11

OFFICE

Dear Sir,  
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter of the  
and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Your obedient servant,  
J. H. [Signature]  
[Address]



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 69 10732  |                         |   |                                     | BALTIMORE CITY HEALTH DEPARTMENT  |   | REG. NO. 69 10732   |  |
|---|-------------------------|---|-------------------------------------|---|---|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Frey George T</b>   |                         |   |                                     | 2. DATE AND HOUR OF DEATH<br><b>10-30-69 6:40 A.M.</b>  |   |   |  |
| 3. PLACE IN BALTIMORE MARYLAND, WHERE PRONOUNCED DEAD<br><b>36 Franklin Square Hospital</b>   |                         |   |                                     | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>805</b> |   |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>36 Franklin Square Hospital</b>   |                         |   |                                     | C. CITY OR TOWN<br><b>Baltimore</b>   |   | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
|   |                         |   |                                     | E. STREET AND NUMBER<br><b>2006 E North Ave</b>   |   |   |  |
| 5. SEX<br><b>Male</b>   | 6. RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>11/22/76</b> | 9. AGE (In years last birthday)<br><b>92</b>  | 10. Under 1 Yr. Months: Days: Hours: Min. | 11. BIRTHPLACE (State or foreign country)<br><b>Penna.</b>                                    |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Brick Layer</b>   |                         |   |                                     | 10B. KIND OF BUSINESS OR INDUSTRY   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Josiah Frey</b>   |                         |   |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Emma Radley</b>  |   |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                         | 16. SOCIAL SECURITY NO.<br><b>215-01-2188A</b>  |                                     | 17. INFORMANT<br><b>Miss Virginia Frey</b>  |   | ADDRESS<br><b>Same</b>  |  |
| 18. <b>436.91</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><b>Cerebrovascular accident</b><br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.<br><b>Gen'l Arteriosclerosis</b> |                         |   |                                     | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Gen'l Arteriosclerosis</b>   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>sev weeks</b><br><b>Years</b>              |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                         |   |                                     |   |   |   |  |
| 19A. DATE OF OPERATION<br><b>10-20</b>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                     | 20A. AUTOPSY? (Yes or No)   |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                     | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                                     | 21F. HOW DID INJURY OCCUR?  |   |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10-20</b> 19 <b>69</b> to <b>10-30</b> 19 <b>69</b> that (I) (we) last saw the deceased alive on <b>10-30</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                         |   |                                     |   |   |   |  |
| 23A. SIGNATURE<br><b>Stuart H. Drager</b>   |                         |   |                                     | 23B. DATE SIGNED<br><b>10-30-69</b>   |   | 23C. PHYSICIAN'S NAME (Type)<br><b>DEGREE</b>   |  |
| 23D. ADDRESS<br><b>DEGREE</b>   |                         |   |                                     | 23E. ADDRESS  |   |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 24B. DATE<br><b>11/3/69</b>   |                                     | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial Park</b>   |   | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>                   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 3 1969</b>  |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>   |                                     | 25C. FUNERAL DIRECTOR<br><b>Leonard J. Ruck Inc.</b>  |   | ADDRESS<br><b>Baltimore, Maryland</b>   |  |

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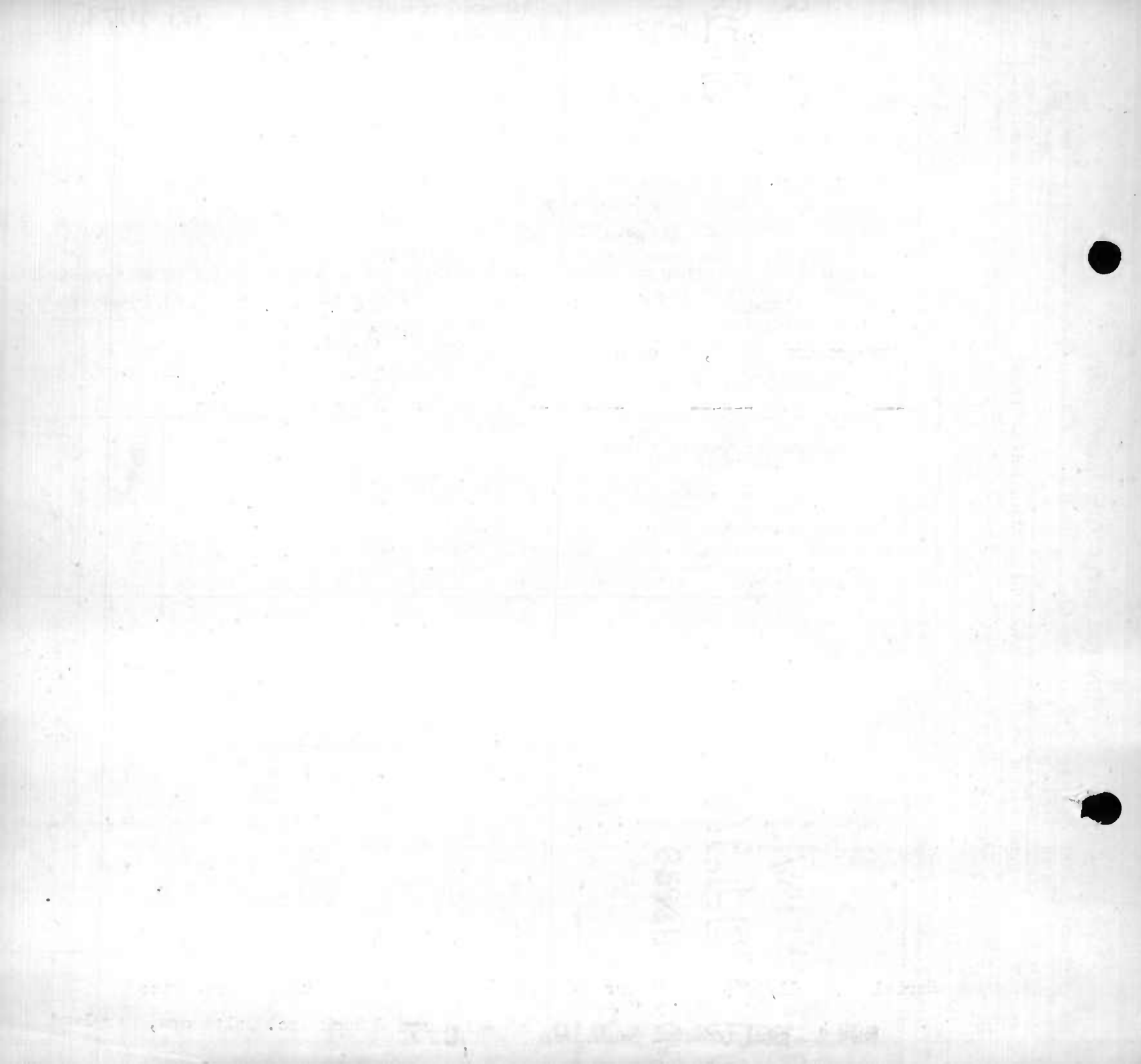
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 69 10733 CERTIFICATE OF DEATH

REG. NO. **69 10733**

|  |                         |   |   |   |   |
|--|-------------------------|---|---|---|---|
| BIRTH NO.  |                         | 1. NAME OF DECEASED<br>(Type or Print) <b>SOLER, BERNARDO</b>   |   | 2. DATE AND HOUR OF DEATH<br><b>10.30.69</b> <b>12:20</b> A. M.   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>JOHNS HOPKINS HOSPITAL</b><br><b>33 601 N BROADWAY - BALTIMORE</b>   |                         |   |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Puerto Rico</b><br>B. COUNTY <b>SAN JUAN, PUERTO RICO</b><br>C. CITY OR TOWN <b>SAN JUAN</b><br>D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>E. STREET AND NUMBER <b>EL VERDE DEVELOPMENT POST OFFICE 331</b> |   |
| 5. SEX<br><b>MALE</b>  | 6. RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9-24-09</b>                        | 9. AGE (In years last birthday) <b>60</b>   | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>TOBACCO ADMINISTRATOR</b>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>PLANTATION-TOBACCO</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>PUERTO RICO</b>   | 12. CITIZEN OF WHAT COUNTRY?<br><b>PUERTO RICO</b>        |
| 13. FATHER'S NAME<br><b>BERNARDO SOLER, Antonio</b>  |                         |   | 14. MOTHER'S MAIDEN NAME<br><b>BELEN ORTIZ</b>            |   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>---</b>   |                         | 16. SOCIAL SECURITY NO.<br><b>-----</b>   | 17. INFORMANT<br><b>Mrs Luz Soler</b> Address <b>Same</b> |   |   |
| 18. <b>74691</b> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>HEART FAILURE</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>SEVERE AORTIC STENOSIS</b><br><b>CORONARY HEART DISEASE</b><br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |                         |   |   |   |   |
| 19A. DATE OF OPERATION<br><b>10-20-69</b>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |   | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10-20-69</b> <b>19</b> to <b>10-30-69</b> <b>19</b> and that (I) (we) lost saw the deceased alive on <b>10-30-69</b> <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                         |   |   |   |   |
| 23A. SIGNATURE<br><b>David Leiberg, MD</b><br>23C. PHYSICIAN'S NAME (Type)<br><b>DAVID LEIBERG</b>   |                         |   |   | 23B. DATE SIGNED<br><b>10.30.69</b><br>Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         |   |   | 24B. DATE<br><b>11/3/69</b>   |   |
| 24C. NAME of CEMETERY or CREMATORY<br><b>Caguas Cemetery</b>   |                         |   |   | 24D. LOCATION (City, town, or county) (State)<br><b>Caguas Puerto Rico</b>  |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 3 1969</b>   |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Sullivan, Jr.</b>  |   | 25C. FUNERAL DIRECTOR<br><b>Leonard J. Ruck Inc. Baltimore, Maryland</b>  |   |



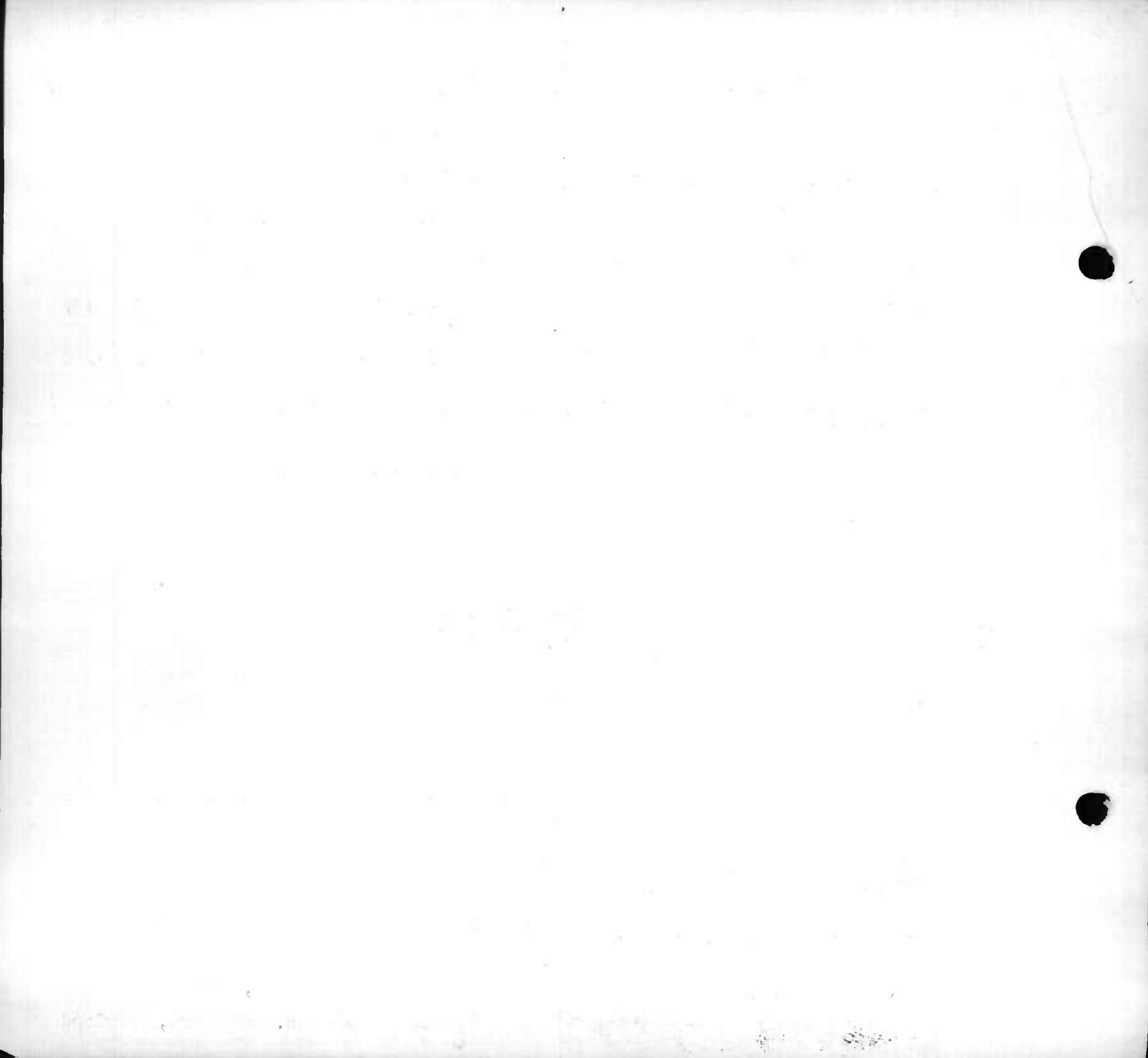
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT 69 10734 CERTIFICATE OF DEATH

REG. NO. 69 10734

|   |                     |   |  |  |  |
|---|---------------------|---|--|--|--|
| BIRTH NO.   |                     | 1. NAME OF DECEASED<br>(Type or Print) <b>ALBERT W WHEELER</b>  |  | 2. DATE AND HOUR OF DEATH<br><b>10-29-69 11:45 A.M.</b>                    |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>MARYLAND GENERAL HOSPITAL</b><br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |                     |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>1401</b><br>C. CITY OR TOWN <b>BALTIMORE</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>1615 PARK AVE.</b> |  |  |
| 5. SEX<br><b>M</b>  | 6. RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>11/28/1896</b>                                      | 9. AGE (In years last birthday) <b>72</b>        |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>SALESMAN</b>  |                     | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>               |  |
| 13. FATHER'S NAME<br><b>ALBERT I WHEELER</b>  |                     |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>YES WWI</b>  |                     |   | 16. SOCIAL SECURITY NO.<br><b>215-05-0651</b>  |  | 17. INFORMANT<br><b>MR. L.S. BOWMAN (NEPHEW)</b> |
| 18. <b>410.9 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>MYOCARDIAL INFARCT</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                     |   | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>MYOCARDIAL INFARCT</b>  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH     |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>MALNUTRITION AND DEHYDRATION.</b>  |                     |   |  |  |  |
| 19A. DATE OF OPERATION<br><b>0</b>  |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>                                     |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE OLD INJURY OCCURRED (If in Baltimore City, give exact location) |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)  |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW OLD INJURY OCCURRED   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10-28 1969</b> to <b>10-29 1969</b> that (I) (we) last saw the deceased alive on <b>10-29 1969</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                     |   |  |  |  |
| 23A. SIGNATURE<br><b>Artemio M. Cuevas, M.D.</b><br>DEGREE  |                     |   |  | 23B. DATE SIGNED<br><b>10/29/69</b>  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>ARTEMIO M. CUEVAS, M.D.</b><br>DEGREE  |                     |   |  | 23D. ADDRESS<br><b>Maryland Gen. Hospital</b>                              |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                     | 24B. DATE<br><b>11/1/69</b>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Woodlawn</b>                      |  |
| 24D. LOCATION<br><b>Baltimore, Maryland</b>   |                     | 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 3 1969</b>  |  |  |  |
| 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>   |                     | 25C. FUNERAL DIRECTOR<br><b>Leonard J. Ruck Inc. Baltimore, Maryland</b>  |  |  |  |



# FUNERAL DIRECTOR: IMPORTANT

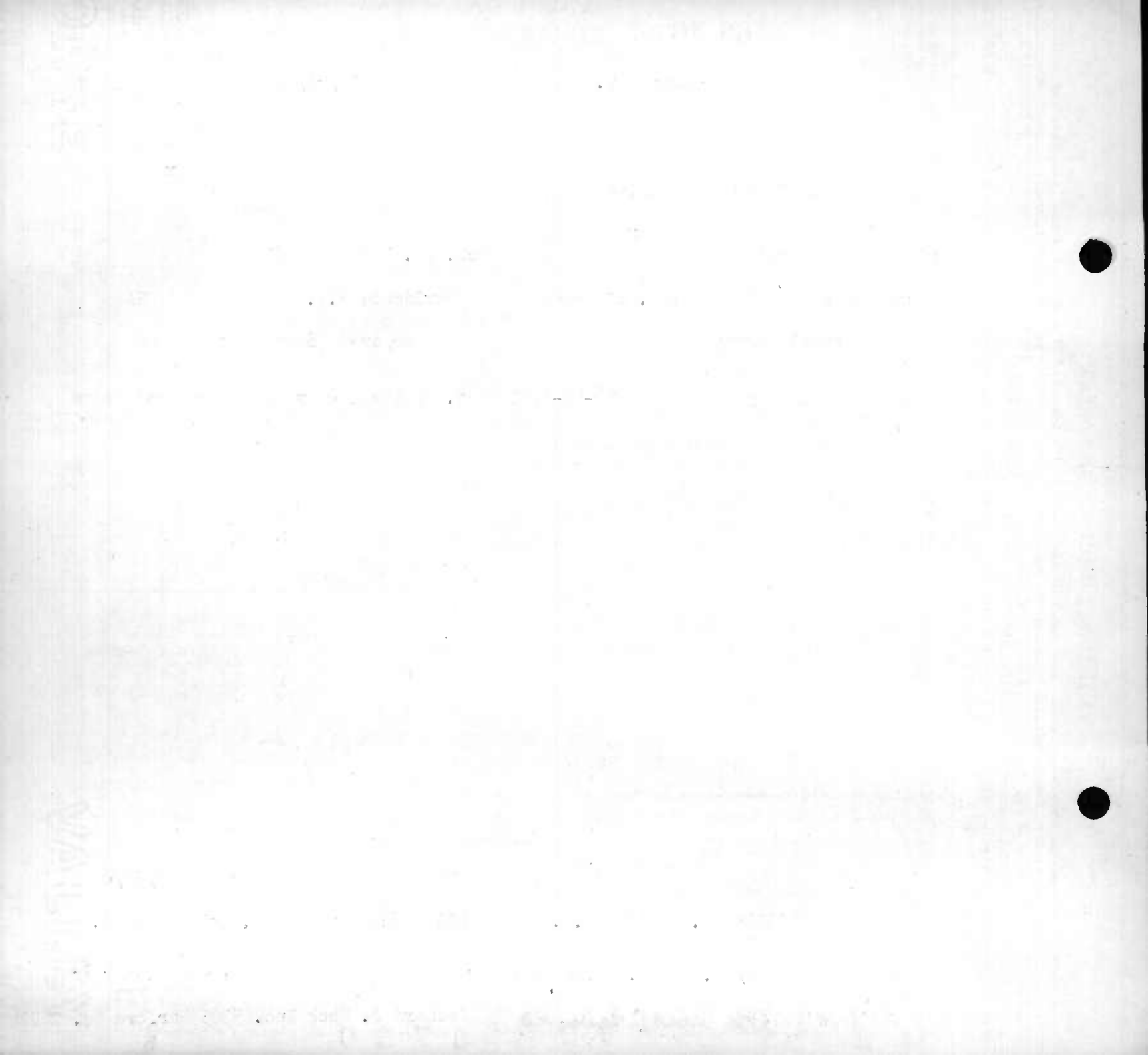
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 69 10735 CERTIFICATE OF DEATH

REG. NO.

69 10735

|   |                             |   |  |   |  |   |  |
|---|-----------------------------|---|--|---|--|---|--|
| BIRTH NO.   |                             | 1. NAME OF DECEASED<br>(Type or Print)<br><b>John Thomas Murray Sr.</b>   |  | 2. DATE AND HOUR OF DEATH<br><b>10/29/69</b>  |  | 3. LEAF M.  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                             | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE<br><b>Maryland</b><br>B. COUNTY<br><b>2739</b>            |  | C. CITY OR TOWN<br><b>Baltimore</b>   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>00</b>   |                             | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>4518 Northwood Drive</b>   |  | E. STREET AND NUMBER<br><b>4518 Northwood Drive</b>                                 |  |   |  |
| 5. SEX<br><b>Male</b>   | 6. RACE<br><b>Caucasian</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Oct. 24. 1908</b> | 9. AGE (In years last birthday)<br><b>61</b>  | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Hours: Min.  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Economists</b>  |                             | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Dept. of Labor</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Providence R.I.</b>                 |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Daniel Murray</b>   |                             | 14. MOTHER'S MAIDEN NAME<br><b>Margaret McPartland</b>  |  |   |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes WW 2</b>   |                             | 16. SOCIAL SECURITY NO.<br><b>220-42-6772</b>   |  | 17. INFORMANT ADDRESS<br><b>Mrs. Louise Murray 4518 Northwood Drive</b>             |  |   |  |
| 18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>151.9 I</b><br><b>Carcinoma of the Stomach</b>   |                             | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>Carcinoma of the Stomach</b>  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| II. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                             | (B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____  |  |   |  |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                             |   |  |   |  |   |  |
| 19A. DATE OF OPERATION<br><b>0</b>  |                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><b>No</b>  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |   |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)  |                             | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |  |   |  |
| 22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Sept 1969</b> to <b>Oct 29 1969</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>Oct 29 1969</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ( <del>did not</del> ) view the body after death. |                             |   |  |   |  |   |  |
| 23A. SIGNATURE<br><b>William H. Fusting M.D.</b>  |                             |   |  | 23B. DATE SIGNED<br><b>10/30/69</b>   |  | 23C. PHYSICIAN'S NAME (Type)<br><b>William H. Fusting M.D.</b>                                |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                             | 24B. DATE<br><b>11/2/69.</b>  |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>St. Marks Cemetery</b>                     |  | 24D. LOCATION (City, town, or county) (State)<br><b>Jamestown, Rhode Island.</b>              |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 3 1969</b>  |                             | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher, M.D.</b>   |  | 25C. FUNERAL DIRECTOR ADDRESS<br><b>Leonard J. Ruck Inc. 5305 Harford Rd. 21214</b> |  |   |  |





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |  |  |  | REG. NO. 69 10736   |  |
|---|--|--|--|---|--|
| BIRTH NO.   |  | 69 10736   |  | CERTIFICATE OF DEATH  |  |
| 1. NAME OF DECEASED<br>(Type or Print)  |  | Virginia Chamot  |  | 2. DATE AND HOUR OF DEATH<br>10/29/69   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  |  | M.  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION  |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |  | A. STATE B. COUNTY  |  |
| 00  |  | 3713 Springdale Avenue   |  | Maryland 1538   |  |
| 5. SEX<br>Female  |  | 6. RACE<br>Caucasian   |  | C. CITY OR TOWN<br>Baltimore  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br>Sept. 3, 1892  |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. AGE (In years last birthday)<br>77  |  | E. STREET AND NUMBER<br>3713 Springdale Avenue  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Homemaker  |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br>Buffalo New York                                 |  |
| 13. FATHER'S NAME<br>Martin Moeller   |  | 14. MOTHER'S MAIDEN NAME<br>Lena Knoenig   |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>no  |  | 16. SOCIAL SECURITY NO.<br>070-05-5517   |  | 17. INFORMANT ADDRESS<br>Mrs. H. Edwin Boyd 3713 Springdale Avenue                            |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>Carcinoma of the<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>Degenerative state<br>(C) DUE TO, OR AS A CONSEQUENCE OF:<br>Marked arteriosclerosis |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |  |  |   |  |
| 19A. DATE OF OPERATION  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)<br>No   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |  |
| 21D. TIME OF INJURY (APPROX.)   |  | 21E. INJURY OCCURRED   |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 8-6 1969 to 10-29 1969, that (I) last saw the deceased alive on 10-28 1969 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 10 AM   |  | 23A. SIGNATURE<br>Thomas R. Abbott   |  | 23B. DATE SIGNED<br>10/29/69  |  |
| 23C. PHYSICIAN'S NAME (Type)<br>Thomas Abbott M.D.  |  | 23D. ADDRESS<br>4509 Liberty Heights Avenue Balto. Md.   |  | 23E. FUNERAL DIRECTOR<br>Leonard J. Ruck Inc. 5305 Harford Rd. 21214                          |  |
| 24A. BURIAL CREMATION REMOVAL (Specify)<br>Burial   |  | 24B. DATE<br>11/3/69   |  | 24C. NAME OF CEMETERY or CREMATORY<br>Buffalo Cemetery  |  |
| 24D. LOCATION (City, town, or county) (State)<br>Cheektowaga, N.Y.  |  | 24E. DATE REC'D BY HEALTH DEPT.<br>NOV 3 1969  |  | 24F. NAME OF REGISTRAR<br>R. E. J. J. J.  |  |

10-27-29  
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10-27-29

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
69 10737 CERTIFICATE OF DEATH

REG. NO.

69 10737

|  |                      |   |   |
|--|----------------------|---|---|
| BIRTH NO.  |                      | 2. DATE AND HOUR OF DEATH   |   |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Clarence K. Espey</u>  |                      | 10/29/69 1:00 A.M.  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                      | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)   |   |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>Maryland General Hosp.</u>   |                      | A. STATE <u>MD</u> B. COUNTY <u>BALTO</u>   |   |
|  |                      | C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |
|  |                      | E. STREET AND NUMBER <u>2805 Evergreen Ave.</u>   |   |
| 5. SEX <u>M</u>  | 6. RACE <u>N - W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/4/92</u>            |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED CLERK -</u>   |                      | 10B. KIND OF BUSINESS OR INDUSTRY <u>oil clerk</u>  | 9. AGE (In years last birthday) <u>77</u> |
| 11. BIRTHPLACE (State or foreign country) <u>Balto, Md.</u>  |                      | 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>  |   |
| 13. FATHER'S NAME <u>Romeo Espey</u>   |                      | 14. MOTHER'S MAIDEN NAME <u>Maryne Leysen</u>   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes or unknown) <u>Yes</u> If yes, give war or dates of service <u>WW I</u>  |                      | 16. SOCIAL SECURITY NO. <u>214-01-4076</u>  |   |
| 17. INFORMANT <u>MR. WM. J. GREEN</u>  |                      | ADDRESS <u>6834 QUEENS FERRY RD. BALTO. MD. 21212</u>   |   |
| 18. <u>492X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH   |                      | CAUSE OF DEATH  |   |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   |                      | (A) IMMEDIATE CAUSE <u>Bronchopneumonia</u>   |   |
| ANTECEDENT CAUSES  |                      | DUE TO, OR AS A CONSEQUENCE OF: <u>Emphysema, bullous</u>   |   |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                      | (B) <u>pan - lobular, severe</u>  |   |
|  |                      | (C) <u>Ischemic heart disease years</u>   |   |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                      |   |   |
| 19A. DATE OF OPERATION <u>2</u>  |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |
| 20A. AUTOPSY? (Yes or No) <u>Yes</u>   |                      | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                      | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)   |   |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                      | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10/27/69</u> to <u>10/29/69</u> that (I) (we) last saw the deceased alive on <u>10/29/69</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                      |   |   |
| 23A. SIGNATURE <u>Michael Yen M.D.</u>   |                      | 23B. DATE SIGNED <u>10/29/69</u>  |   |
| 23C. PHYSICIAN'S NAME (Type) <u>Michael Yen M.D.</u>   |                      | 23D. ADDRESS <u>827 Linden Avenue Balto, Md.</u>  |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |                      | 24B. DATE <u>11/1/69</u>  |   |
| 24C. NAME OF CEMETERY OR CREMATORY <u>MORELAND MEM. CEMETERY</u>   |                      | 24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>   |   |
| 25A. DATE REC'D BY HEALTH DEPT. <u>NOV 3 1969</u>  |                      | 25B. NAME OF REGISTRAR <u>Phyllis E. Gable, R.D.</u>  |   |
| 25C. FUNERAL DIRECTOR <u>LEONARD J. ROCK, INC.</u>   |                      | ADDRESS <u>BALTO. MD. 21214</u>   |   |



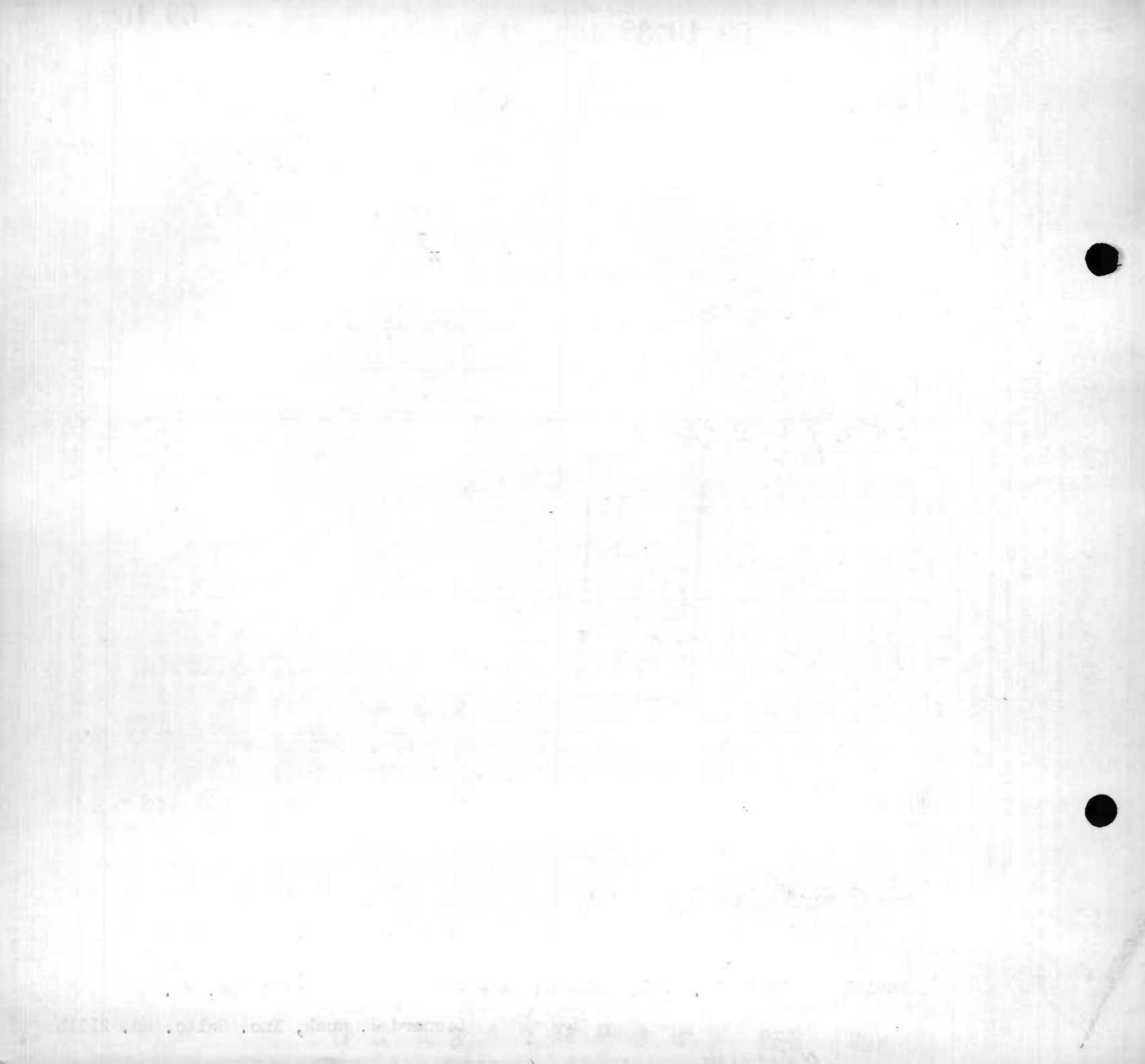
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 69 10738 CERTIFICATE OF DEATH

REG. NO. 69 10738

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| BIRTH NO.   |  | 1. NAME OF DECEASED<br>(Type or Print)<br>MILDRED D. MCGARVEY   |  | 2. DATE AND HOUR OF DEATH<br>10/26/69 - 7:30 P.M.   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE<br>MARYLAND<br>B. COUNTY<br>902 |  | C. CITY OR TOWN<br>BALTIMORE  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>74<br>UNION MEMORIAL HOSPITAL   |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 5. SEX<br>F   |  | 6. RACE<br>W  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH<br>2-2-97  |  | 9. AGE (In years lost birthday)<br>72   |  | 10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>RETIRED Housewife  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br>MARYLAND   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 13. FATHER'S NAME<br>FREDERICK BREMMER  |  | 14. MOTHER'S MAIDEN NAME<br>MARY HOPKINS  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No  |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br>HUSBAND - SAMUEL ALBERT MCGARVEY   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of death, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)<br>CAUSE<br>IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>CARCINOMA OF THE PANCREAS<br>D.H.  |  | 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if on, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 19A. DATE OF OPERATION<br>10-7-69<br>3-7-24-69  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>FRACTURE, RT. HIP   |  | 20A. AUTOPSY? (Yes or No)<br>YES  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>HOME                                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>3401 LAKE MONTEBELLO DR.  |  |
| 21D. TIME OF INJURY (APPROX.)<br>9-18-69  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>              |  | 21F. HOW DID INJURY OCCUR?<br>FALL  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 9-18-1969 to 10-26-1969, that (I) (we) lost saw the deceased alive on 10-26-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |   |  |   |  |
| 23A. SIGNATURE<br>Lillian C. Scharfman  |  | 23B. DATE SIGNED<br>10-26-69  |  | 23C. PHYSICIAN'S NAME (Type)<br>V   |  |
| 23D. ADDRESS<br>UNION MEMORIAL HOSPITAL   |  | 23E. DEGREE   |  | 23F. DEGREE   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |  | 24B. DATE<br>10/31/69   |  | 24C. NAME OF CEMETERY or CREMATORY<br>Holy Redeemer Cemetery  |  |
| 24D. LOCATION<br>Baltimore, Md.   |  | 24E. DATE REC'D BY HEALTH DEPT.   |  | 24F. NAME OF REGISTRAR<br>Leonard J. Buck, Inc. Balto. Md. 21214  |  |
| 24G. DATE REC'D BY HEALTH DEPT.   |  | 24H. NAME OF REGISTRAR  |  | 24I. FUNERAL DIRECTOR<br>Leonard J. Buck, Inc. Balto. Md. 21214   |  |



69 10739 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 10739

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

GORDON A. MILLS

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

10

30

69

4:55 PM.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
OR INSTITUTION ADDRESS OR LOCATION)

Union Memorial Hospital D.O.A.

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

Oct. 30, 1969

4:55 PM.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

Male

7. RACE

White

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

Oct 27, 1907

10. AGE (In years  
last birthday)

62 30

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

4513 Weitzel Ave.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles O Mills

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Die-Setter

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Etta M Disharoon

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

212-03-2526

18. INFORMANT

Mrs Mary Mills

ADDRESS

Same

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Isidore Mihalakis, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Oct. 31, 1969

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

11/3/69

24C. NAME of CEMETERY or CREMATORY

Holy Redeemer

24D. LOCATION (City, town, or county)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

NOV 2

25B. NAME OF REGISTRAR

Robert E. Faber, M.D.

25C. FUNERAL DIRECTOR

Leonard J Ruck Inc Baltimore, Maryland

ADDRESS

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FUNERAL DIRECTOR: IMPORTANT

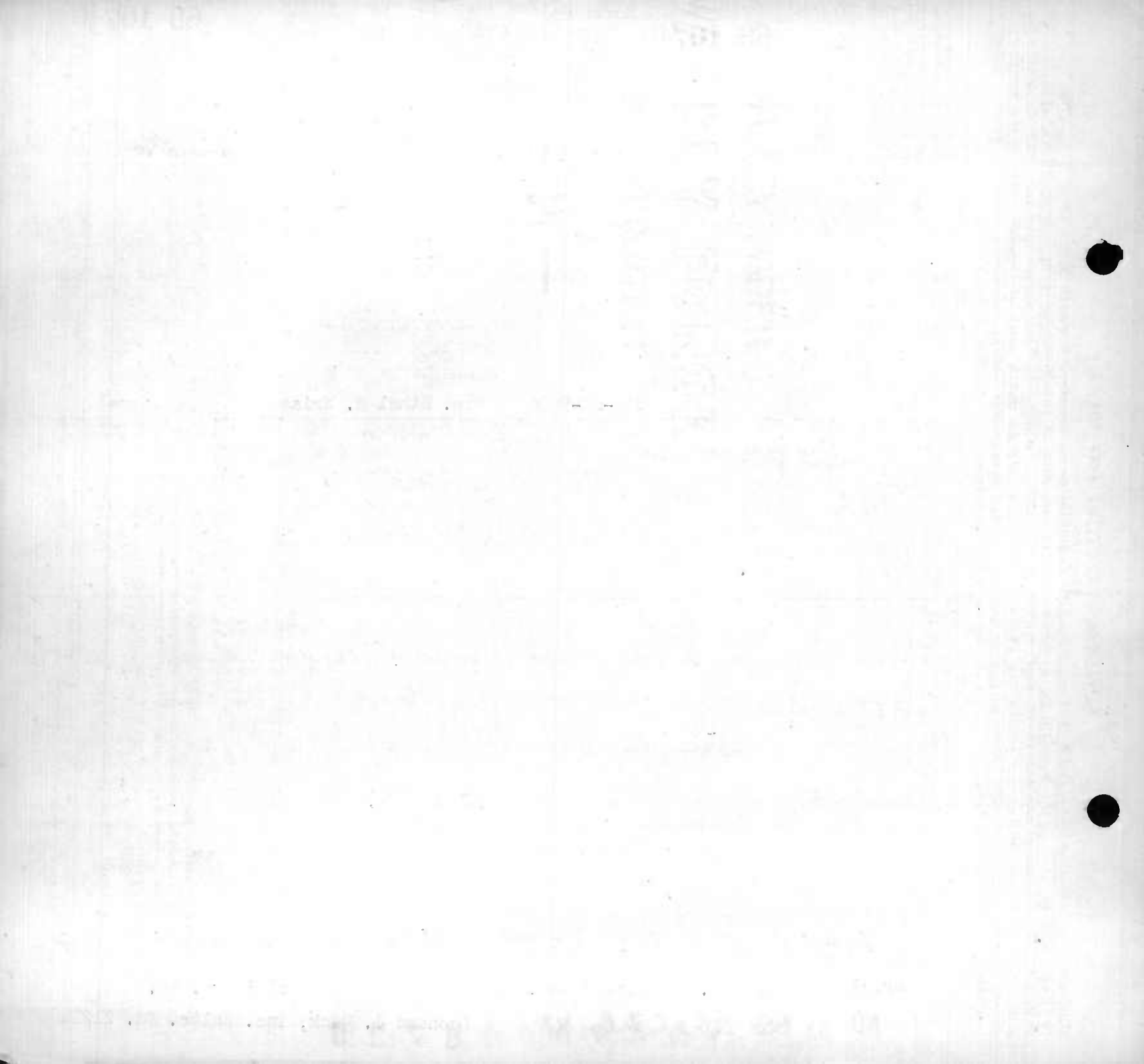
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 10740

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 10740

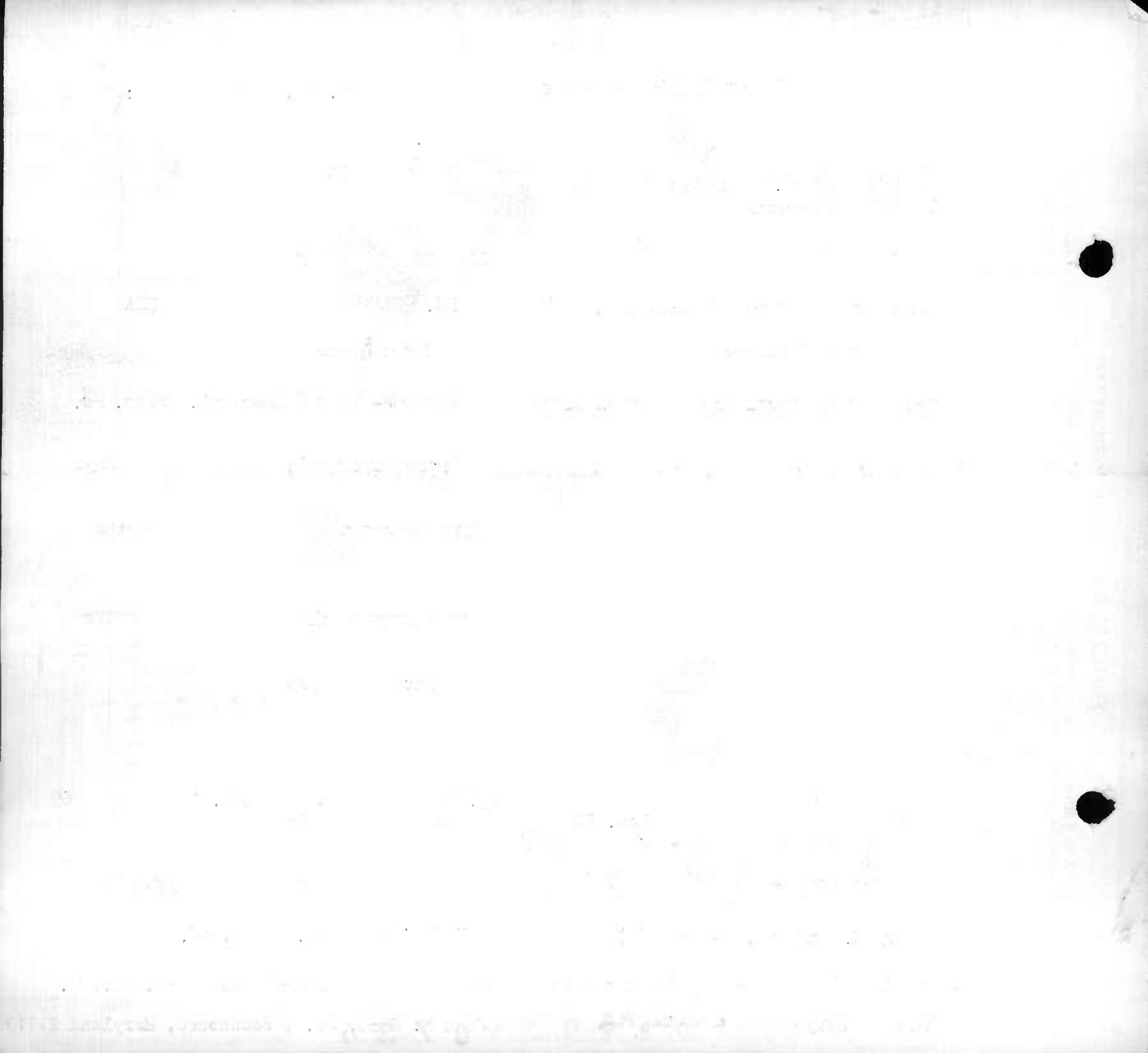
|  |                     |   |   |  |   |
|--|---------------------|---|---|--|---|
| BIRTH NO.  |                     | 1. NAME OF DECEASED<br>(Type or Print) <b>HENRY JAMES KRISS</b>   |   | 2. DATE AND HOUR OF DEATH<br><b>10/31/69 8:05 A M.</b>                   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                     |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>2734</b> |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>NORTH CHARLES GENERAL</b>   |                     |   | C. CITY OR TOWN<br><b>BALTIMORE</b>   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>49 BALTO. MD. HOSPITAL</b>  |                     |   | E. STREET AND NUMBER<br><b>4106 WHITE AVE</b>   |  |   |
| 5. SEX<br><b>M</b>   | 6. RACE<br><b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>10/23/06</b>                                      | 9. AGE (In years last birthday)<br><b>63</b>  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>MECHANIC</b>   |                     | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>BALTO. TRANSIT CO</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>             | 12. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   |
| 13. FATHER'S NAME<br><b>ANTHONY KRISS</b>  |                     |   | 14. MOTHER'S MAIDEN NAME<br><b>ANNIE LOUKOTA</b>  |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                     | 16. SOCIAL SECURITY NO.<br><b>219-01-9026</b>   |   | 17. INFORMANT<br><b>Mrs. Ethel M. Kriss</b>                              |   |
|  |                     |   |   | ADDRESS<br><b>(Same)</b>   |   |
| 18. <b>162.1 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Massive GI Bleeding 2° Duodenal ulcer</b>   |                     |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                     |   | (A) IMMEDIATE CAUSE<br><b>TERMINAL CARCINOMA</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>PULMONARY CARCINOMA 7/69</b>                  |  |   |
|  |                     |   | (B) _____<br>(C) _____  |  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                     |   |   |  |   |
| 19A. DATE OF OPERATION<br><b>2</b>   |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>            |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><b>NO</b>   |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |   | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10/30/1969</b> to <b>10/31/1969</b> , that (we) lost saw the deceased alive on <b>10/31/1969</b> and that in (my) <b>Dr</b> opinion death occurred on the date and hour and from the causes stated above. (I) (We) <b>Dr</b> view the body after death. |                     |   |   |  |   |
| 23A. SIGNATURE<br><b>Juanito F. Lopez Jr MD</b>  |                     |   |   | 23B. DATE SIGNED<br><b>10/21/69</b>                                      |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>JUANITO F. LOPEZ JR MD</b>  |                     |   |   | 23D. ADDRESS<br><b>NORTH CHARLES GEN. HOSPITAL</b>                       |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                     | 24B. DATE<br><b>11/3/69.</b>  |   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>           |   |
|  |                     |   |   | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>   |   |
| 25A. DATE REC'D BY HEALTH DEPT<br><b>NOV 3 1969</b>  |                     | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor Jr</b>  |   | 25C. FUNERAL DIRECTOR<br><b>Leonard J. Rack, Inc. Balto. Md. 21214</b>   |   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

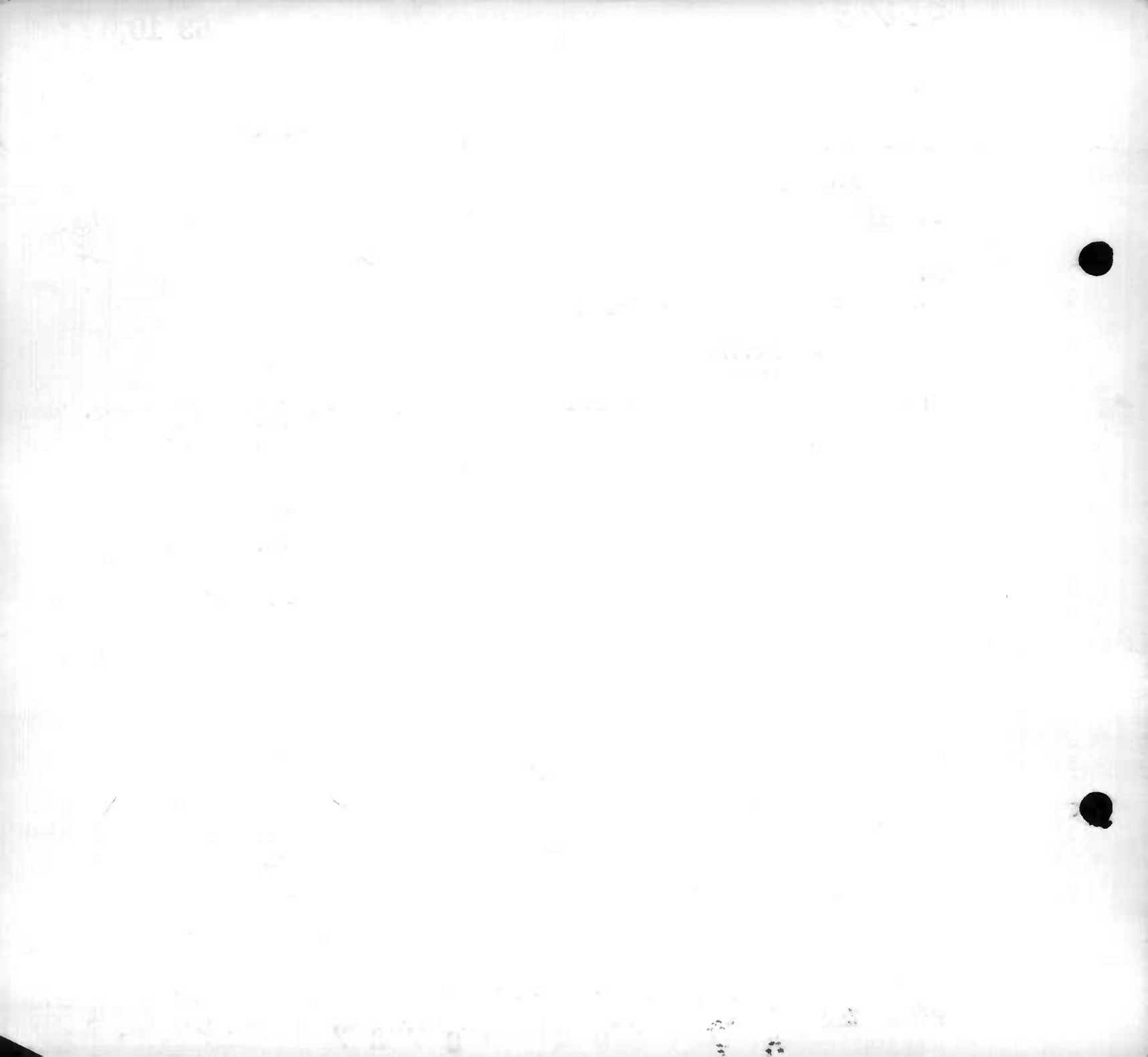
|  |                     |   |  |  |   |
|--|---------------------|---|--|--|---|
| BIRTH NO. <u>69 10741</u>  |                     | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. <u>69 10741</u>   |   |
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>George William Dinsmore</b>   |                     |   | 2. DATE AND HOUR OF DEATH<br><b>Oct. 30, 1969 1:50 A M.</b>  |  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>US Public Health Service Hospital<br/>3100 Wyman Parkway</b>   |                     |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>Washington</b><br>C. CITY OR TOWN <b>Rohrersville</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER |  |   |
| 5. SEX<br><b>M</b>   | 6. RACE<br><b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10/8/22</b>   | 9. AGE (In years last birthday)<br><b>47</b>                             | If Under 1 Yr. Months Days<br>If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Machine operator</b>   |                     | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Cement Mfg.</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>                  |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                     |   | 13. FATHER'S NAME<br><b>Edward Dinsmore</b>  |  |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Grace Rhrer</b>   |                     |   | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes USA 1942-1946</b>   |  |   |
| 16. SOCIAL SECURITY NO.<br><b>214-14-6480</b>  |                     |   | 17. INFORMANT ADDRESS<br><b>Records- US PHS Hospital, Balto, Md.</b>   |  |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>200.1 I</b><br><b>BRONCHOPNEUMONIA</b>  |                     |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Days</b>  |  |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br><b>PULMONARY EMBOLI</b>   |                     |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Months</b>  |  |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>Pulmonary emboli</b>  |                     |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Weeks</b>   |  |   |
| 19A. DATE OF OPERATION<br><b>2</b>   |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><b>yes</b>                                  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Aug. 27</b> 19 <b>69</b> to <b>Oct. 30</b> 19 <b>69</b> that (I) (we) last saw the deceased alive on <b>Oct. 30</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                     |   |  |  |   |
| 23A. SIGNATURE<br><b>Gary E. Feldman, M.D.</b>   |                     |   |  | 23B. DATE SIGNED<br><b>10/30/69</b>                                      |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Gary E. Feldman, SA Surg (R)</b>  |                     |   |  | 23D. ADDRESS<br><b>US PHS Hospital, Balto, Md.</b>                       |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Removal-Burial</b>  |                     | 24B. DATE<br><b>11- 1- 69</b>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Rohrersville Cemetery</b>       |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>Rohrersville, Wash. Co., Md.</b>   |                     | 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 3 1969</b>  |  |  |   |
| 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>  |                     | 25C. FUNERAL DIRECTOR ADDRESS<br><b>John E. East, Jr., Boonsboro, Maryland 21713</b>  |  |  |   |



# FUNERAL DIRECTOR: IMPORTANT

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|  |  |   |  |   |  |
|--|--|---|--|---|--|
| <div style="font-size: 2em; font-weight: bold;">S-455</div> <div style="font-size: 1.5em; font-weight: bold;">69 10742</div>                                     |  | <div style="font-size: 1.2em; font-weight: bold;">BALTIMORE CITY HEALTH DEPARTMENT</div> <div style="font-size: 1.5em; font-weight: bold;">CERTIFICATE OF DEATH</div>   |  | <div style="font-size: 1.2em; font-weight: bold;">REG. NO. 69 10742</div>   |  |
| <div style="font-size: 0.8em; font-weight: bold;">BIRTH NO.</div>  |  | <div style="font-size: 0.8em; font-weight: bold;">1. NAME OF DECEASED</div> <div style="font-size: 0.7em;">(Type or Print)</div>  |  | <div style="font-size: 0.8em; font-weight: bold;">2. DATE AND HOUR OF DEATH</div>   |  |
| <div style="font-size: 0.8em; font-weight: bold;">3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</div>   |  | <div style="font-size: 0.8em; font-weight: bold;">4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</div> <div style="font-size: 0.7em;">A. STATE B. COUNTY</div>   |  | <div style="font-size: 0.8em; font-weight: bold;">5. CITY OR TOWN</div>   |  |
| <div style="font-size: 0.8em; font-weight: bold;">FULL NAME OF HOSPITAL OR INSTITUTION</div>   |  | <div style="font-size: 0.8em; font-weight: bold;">IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION</div>  |  | <div style="font-size: 0.8em; font-weight: bold;">D. INSIDE CITY LIMITS?</div> <div style="font-size: 0.7em;">YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div> |  |
| <div style="font-size: 0.8em; font-weight: bold;">6. RACE</div>  |  | <div style="font-size: 0.8em; font-weight: bold;">7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> <div style="font-size: 0.7em;">WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></div> |  | <div style="font-size: 0.8em; font-weight: bold;">8. DATE OF BIRTH</div>  |  |
| <div style="font-size: 0.8em; font-weight: bold;">10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div>              |  | <div style="font-size: 0.8em; font-weight: bold;">10B. KIND OF BUSINESS OR INDUSTRY</div>   |  | <div style="font-size: 0.8em; font-weight: bold;">11. BIRTHPLACE (State or foreign country)</div>   |  |
| <div style="font-size: 0.8em; font-weight: bold;">13. FATHER'S NAME</div>  |  | <div style="font-size: 0.8em; font-weight: bold;">14. MOTHER'S MAIDEN NAME</div>  |  | <div style="font-size: 0.8em; font-weight: bold;">17. INFORMANT</div>   |  |
| <div style="font-size: 0.8em; font-weight: bold;">15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</div> |  | <div style="font-size: 0.8em; font-weight: bold;">16. SOCIAL SECURITY NO.</div>   |  | <div style="font-size: 0.8em; font-weight: bold;">ADDRESS</div>   |  |
| <div style="font-size: 0.8em; font-weight: bold;">18. CAUSE OF DEATH</div>   |  | <div style="font-size: 0.8em; font-weight: bold;">19. DATE OF OPERATION</div>   |  | <div style="font-size: 0.8em; font-weight: bold;">20A. AUTOPSY? (Yes or No)</div>   |  |
| <div style="font-size: 0.8em; font-weight: bold;">DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div>   |  | <div style="font-size: 0.8em; font-weight: bold;">20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</div>  |  | <div style="font-size: 0.8em; font-weight: bold;">21. INJURY OCCURRED</div>   |  |
| <div style="font-size: 0.8em; font-weight: bold;">18. 410.9 I</div>  |  | <div style="font-size: 0.8em; font-weight: bold;">21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)</div>   |  | <div style="font-size: 0.8em; font-weight: bold;">21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</div>  |  |
| <div style="font-size: 0.8em; font-weight: bold;">18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div>   |  | <div style="font-size: 0.8em; font-weight: bold;">21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</div>  |  | <div style="font-size: 0.8em; font-weight: bold;">21E. HOW DID INJURY OCCUR?</div>  |  |
| <div style="font-size: 0.8em; font-weight: bold;">18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div>   |  | <div style="font-size: 0.8em; font-weight: bold;">21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</div>   |  | <div style="font-size: 0.8em; font-weight: bold;">21F. HOW DID INJURY OCCUR?</div>  |  |
| <div style="font-size: 0.8em; font-weight: bold;">18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div>   |  | <div style="font-size: 0.8em; font-weight: bold;">21E. INJURY OCCURRED</div>  |  | <div style="font-size: 0.8em; font-weight: bold;">21F. HOW DID INJURY OCCUR?</div>  |  |
| <div style="font-size: 0.8em; font-weight: bold;">18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div>   |  | <div style="font-size: 0.8em; font-weight: bold;">21E. INJURY OCCURRED</div>  |  | <div style="font-size: 0.8em; font-weight: bold;">21F. HOW DID INJURY OCCUR?</div>  |  |
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| <div style="font-size: 0.8em; font-weight: bold;">18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div>   |  | <div style="font-size: 0.8em; font-weight: bold;">21E. INJURY OCCURRED</div>  |  | <div style="font-size: 0.8em; font-weight: bold;">21F. HOW DID INJURY OCCUR?</div>  |  |
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| <div style="font-size: 0.8em; font-weight: bold;">18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div>   |  | <div style="font-size: 0.8em; font-weight: bold;">21E. INJURY OCCURRED</div>  |  | <div style="font-size: 0.8em; font-weight: bold;">21F. HOW DID INJURY OCCUR?</div>  |  |
| <div style="font-size: 0.8em; font-weight: bold;">18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div>   |  | <div style="font-size: 0.8em; font-weight: bold;">21E. INJURY OCCURRED</div>  |  | <div style="font-size: 0.8em; font-weight: bold;">21F. HOW DID INJURY OCCUR?</div>  |  |
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| <div style="font-size: 0.8em; font-weight: bold;">18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div>   |  | <div style="font-size: 0.8em; font-weight: bold;">21E. INJURY OCCURRED</div>  |  | <div style="font-size: 0.8em; font-weight: bold;">21F. HOW DID INJURY OCCUR?</div>  |  |
| <div style="font-size: 0.8em; font-weight: bold;">18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div>   |  | <div style="font-size: 0.8em; font-weight: bold;">21E. INJURY OCCURRED</div>  |  | <div style="font-size: 0.8em; font-weight: bold;">21F. HOW DID INJURY OCCUR?</div>  |  |
| <div style="font-size: 0.8em; font-weight: bold;">18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div>   |  | <div style="font-size: 0.8em; font-weight: bold;">21E. INJURY OCCURRED</div>  |  | <div style="font-size: 0.8em; font-weight: bold;">21F. HOW DID INJURY OCCUR?</div>  |  |
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| BIRTH NO.   |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  | 69 10743  |  |
|---|--|--|--|--|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print)  |  | RALPH BAXTER   |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>   |  | Month Day Year Hour<br>October 29, 1969 M.  |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |  | 306 East North Avenue  |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br>October 29, 1969 3:10 P M.   |  |   |  |
| 6. SEX  |  | 7. RACE  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>           |  | C. CITY OR TOWN<br>Baltimore  |  |
| Male  |  | White  |  |  |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 9. DATE OF BIRTH<br>June 28, 1920   |  | 10. AGE (In years last birthday)<br>49   |  | 11. BIRTHPLACE (State or foreign country)<br>West Virginia   |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Steel Worker   |  | 14B. KIND OF BUSINESS OR INDUSTRY<br>Steel Co.   |  | 13. FATHER'S NAME<br>James L. Baxter   |  | 15. MOTHER'S MAIDEN NAME<br>Lola M. Bussard   |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>yes W.W. Two   |  | 17. SOCIAL SECURITY NO.<br>235-34-2886   |  | 18. INFORMANT<br>Van Reener Funeral Home, Marlington, W. Va.   |  | ADDRESS   |  |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>Arteriosclerotic cardiovascular disease  |  | CAUSE OF DEATH<br>Arteriosclerotic cardiovascular disease  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| 20A. DATE OF OPERATION  |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 21. AUTOPSY? (Yes or No)<br>Yes  |  |   |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.  |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |   |  |
| 22D. TIME OF INJURY (APPROX.)   |  | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 22F. HOW DID INJURY OCCUR?   |  |   |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | ACTUAL SIGNATURE<br>Charles S. Springate, M.D.   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |  | DATE SIGNED<br>October 30, 1969   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |  | 24B. DATE<br>11-2-1969   |  | 24C. NAME of CEMETERY or CREMATORY<br>Mountain View  |  | 24D. LOCATION (City, town, or county) (State)<br>Marlington, W. Va.                           |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 3 1969   |  | 25B. NAME OF REGISTRAR<br>Robert E. Fisher, M.D.   |  | 25C. FUNERAL DIRECTOR<br>Wm. Cook-Brooks Towson,   |  | ADDRESS<br>1050 York Road<br>Towson, Md. 21204  |  |

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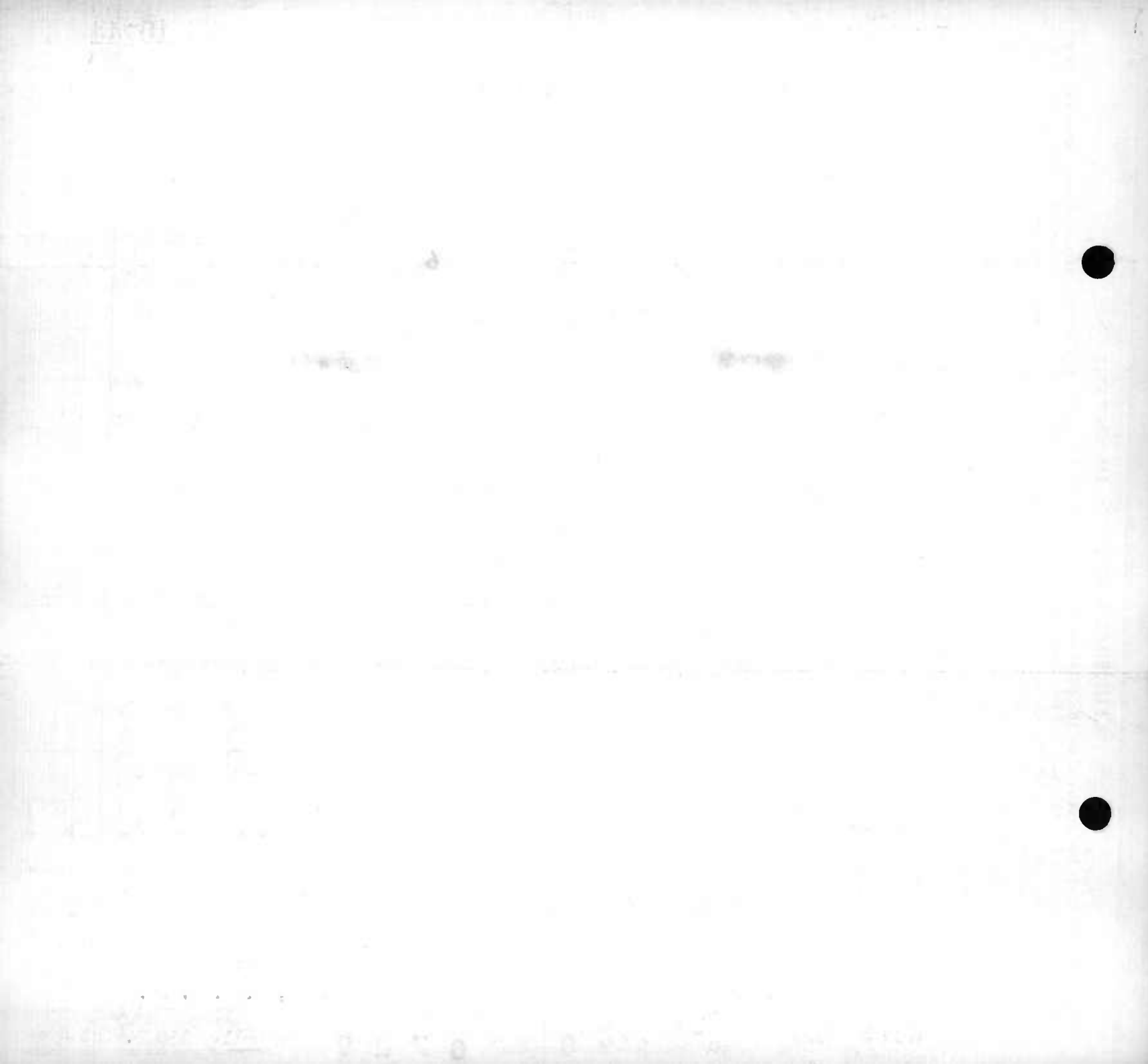
10/10/13



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |                     |   |  |                                    |  |  |   |  |   |  |
|--|---------------------|---|--|------------------------------------|--|--|---|--|---|--|
| 69 10744 CERTIFICATE OF DEATH  |                     |   |  |                                    | REG. NO. 69 10744  |  |   |  |   |  |
| BIRTH NO. <u>H-522</u>   |                     |   |  |                                    | 1. NAME OF DECEASED<br>(Type or Print) <u>MARGARET MARIE HANCOCK</u>   |  |   |  |   |  |
| 2. DATE AND HOUR OF DEATH<br><u>Oct 31, 1969</u> <u>2:40</u> A.M.  |                     |   |  |                                    |  |  |   |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>SOUTH BALTIMORE GENERAL HOSPITAL</u><br><u>43</u>  |                     |   |  |                                    | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>MD.</u><br>B. COUNTY <u>—</u><br>C. CITY OR TOWN <u>BALTIMORE</u><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <u>2521 SUTDEN AVE.</u> |  |   |  |   |  |
| 5. SEX<br><u>F</u>   | 6. RACE<br><u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>4-16-13</u> | 9. AGE (In years last birthday)<br><u>56</u>   | If Under 1 Yr. Months Days   |   | If Under 24 Hrs. Hours Min.  |   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>  |                     |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>AT Home</u>  |                                    | 11. BIRTHPLACE (State or foreign country)<br><u>BALTIMORE, MD.</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                   |  |   |  |
| 13. FATHER'S NAME<br><u>HARRY Hemerich</u>   |                     |   |  |                                    | 14. MOTHER'S MAIDEN NAME<br><u>BESSIE JACKSON</u>  |  |   |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>NO</u>  |                     |   | 16. SOCIAL SECURITY NO.<br><u>389-12-1535</u>  |                                    | 17. INFORMANT<br><u>HUSBAND</u>  |  |   |  | ADDRESS<br><u>2521 SUTDEN AVE. BALTO.</u> |  |
| 18. <u>412.2 I</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><u>CEREBROVASCULAR ACCIDENT, PROBABLY HEMMORHAGE</u><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>HASCVD</u> |                     |   |  |                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |   |  |
| II   |                     |   |  |                                    |  |  |   |  |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (A).  |                     |   |  |                                    |  |  |   |  |   |  |
| 19A. DATE OF OPERATION<br><u>0</u>   |                     |   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                    |  | 20A. AUTOPSY? (Yes or No)  |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |                     |   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |                                    |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |  |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                     |   | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                                    |  | 21F. HOW DID INJURY OCCUR?   |   |  |   |  |
| 22. I certify that <u>(I)</u> (this hospital) attended the deceased from <u>Oct 27</u> 19 <u>69</u> to <u>Oct 31</u> 19 <u>69</u> that <u>(I)</u> (we) last saw the deceased alive on <u>Oct 30</u> 19 <u>69</u> and that <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> (We) (did) (and not) view the body after death.   |                     |   |  |                                    |  |  |   |  |   |  |
| 23A. SIGNATURE<br><u>William Eric Sohn M.D.</u>  |                     |   |  |                                    | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>  |  |   | 23B. DATE SIGNED<br><u>Oct 31, 1969</u>                              |   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>William Eric Sohn</u>   |                     |   |  |                                    | 23D. ADDRESS<br><u>4402 COLBORNE RD. BALTO MD</u>  |  |   |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                     |   | 24B. DATE<br><u>11 3 69</u>  |                                    | 24C. NAME OF CEMETERY OR CREMATORY<br><u>Holy Cross</u>  |  | 24D. LOCATION (City, town, or county) (State)<br><u>Brooklyn, A. A. Co. Md.</u> |  |   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 3 1969</u>   |                     |   | 25B. NAME OF REGISTRAR<br><u>Robert E. Taylor, M.D.</u>  |                                    |  | 25C. FUNERAL DIRECTOR<br><u>Mc Cully</u>                                 |   | ADDRESS<br><u>130 E. Port Ave</u>                                    |   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

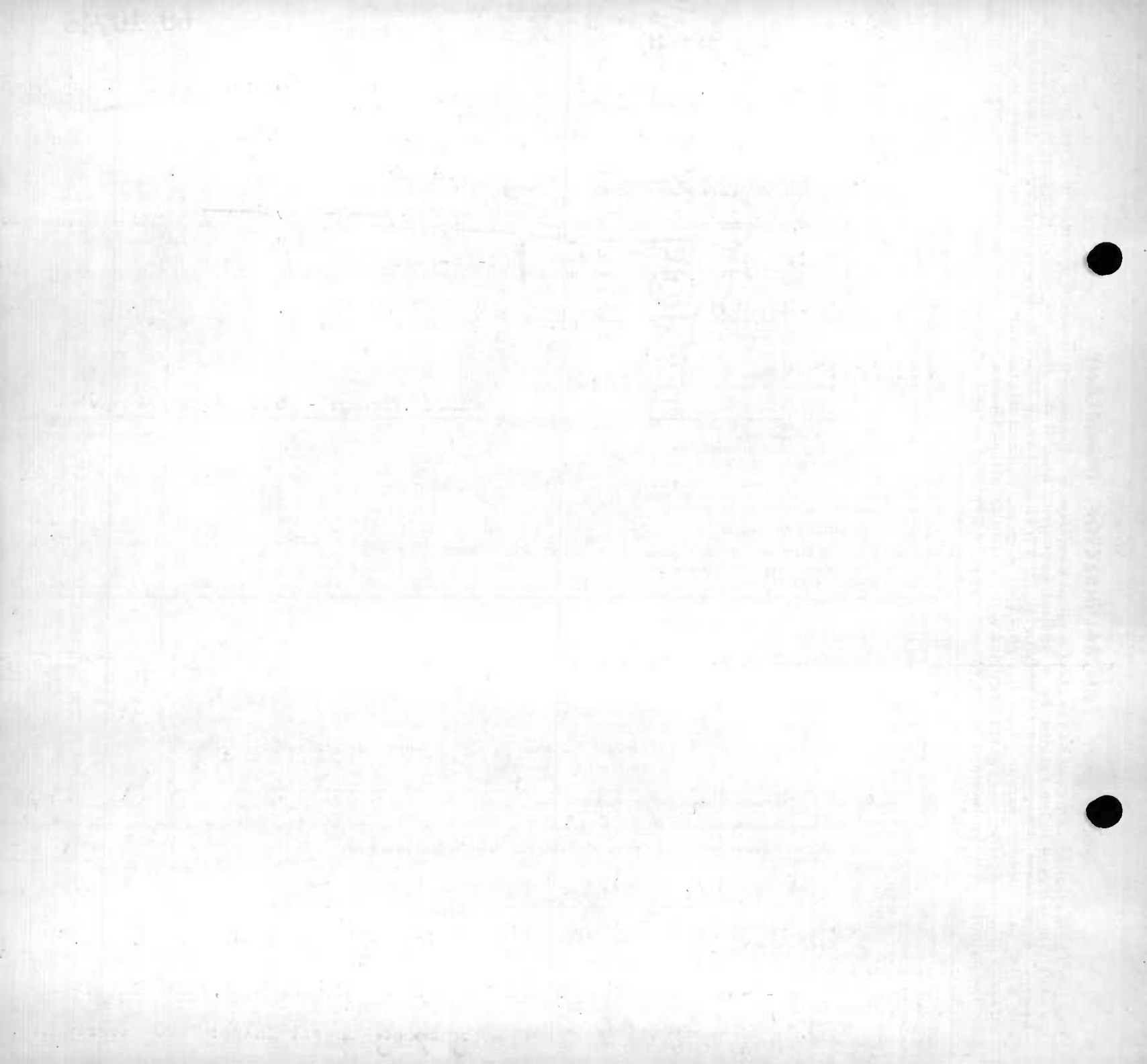
| BALTIMORE CITY HEALTH DEPARTMENT   |  |  |  | REG. NO. <b>69 10745</b>  |  |
|--|--|--|--|---|--|
| A-250  |  | 69 10745   |  | CERTIFICATE OF DEATH  |  |
| BIRTH NO.  |  | 1. NAME OF DECEASED<br>(Type or Print) <b>Beckie ASKIN</b>   |  | 2. DATE AND HOUR OF DEATH<br><b>10/30/69 11:20 A.M.</b>                                       |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>BALTO.</b>                |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>42 SINAI HOSPITAL OF BALTIMORE.</b>   |  | C. CITY OR TOWN<br><b>Baltimore</b>  |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 5. SEX <b>F</b> 6. RACE <b>W</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>2/15/85</b>  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 9. AGE (in years last birthday) <b>84 yrs</b>   |  |
| 13. FATHER'S NAME<br><b>Joseph</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Faga</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Austria</b>                                   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 17. INFORMANT<br><b>Mrs Solomon Rogers</b>   |  | ADDRESS<br><b>Same</b>   |  |   |  |
| 18. <b>345.21</b>  |  | CAUSE OF DEATH   |  |   |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)   |  | (A) IMMEDIATE CAUSE<br><b>STATUS EPILEPTICUS</b><br>DUE TO, OR AS A CONSEQUENCE OF:  |  |   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |  | (B) DUE TO, OR AS A CONSEQUENCE OF:  |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |  | (C) DUE TO, OR AS A CONSEQUENCE OF:  |  |   |  |
| 19A. DATE OF OPERATION   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)<br><b>No</b>  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10/25</b> 19 <b>67</b> to <b>10/30</b> 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |   |  |
| 23A. SIGNATURE<br><b>[Signature]</b>   |  |  |  | 23B. DATE SIGNED<br><b>10/30/69</b>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>[Signature]</b>   |  |  |  | 23D. ADDRESS<br><b>5309 Old Court Rd.</b>   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>11/2/69</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Chapel Ammon</b>                                     |  |
| 24D. LOCATION<br><b>Balto</b>  |  | 24E. NAME OF REGISTRAR<br><b>[Signature]</b>   |  | 24F. FUNERAL DIRECTOR<br><b>Sylvan L. Linn &amp; Son, Inc. 9610 Reisterstown Rd.</b>          |  |
| 25A. DATE RECEIVED BY HEALTH DEPT.<br><b>NOV 3 1969</b>  |  |  |  |   |  |



# FUNERAL DIRECTOR: IMPORTANT

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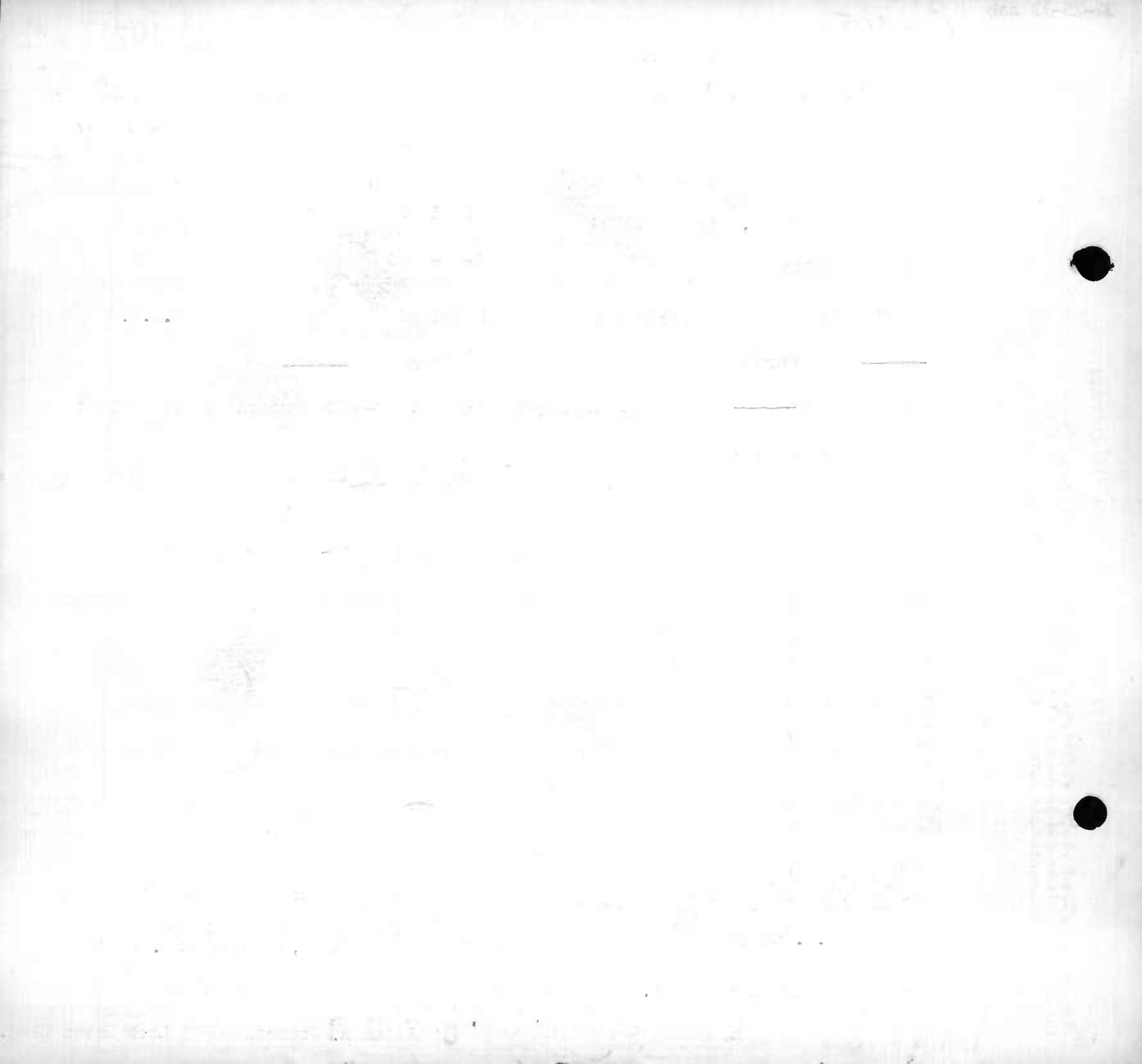
| BALTIMORE CITY HEALTH DEPARTMENT  |         |  |                  | REG. NO. <b>69 10746</b>   |                            |
|---|---------|--|------------------|--|----------------------------|
| C-626   |         | 69 10746   |                  | CERTIFICATE OF DEATH   |                            |
| BIRTH NO.   |         | 1. NAME OF DECEASED<br>(Type or Print)   |                  | 2. DATE AND HOUR OF DEATH  |                            |
|   |         | ELWOOD S. CRIZER   |                  | October 30, 1969 12:30 AM.   |                            |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |         | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)    |                  |  |                            |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><br>90 HAVEN NURSING HOME<br>3939 Penhurst Avenue   |         | A. STATE   |                  | B. COUNTY  |                            |
|   |         | Maryland   |                  | Baltimore  |                            |
|   |         | C. CITY OR TOWN  |                  | D. INSIDE CITY LIMITS?   |                            |
|   |         | Baltimore  |                  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |                            |
|   |         | E. STREET AND NUMBER   |                  |  |                            |
|   |         | 3801 Gwynn Oak Avenue  |                  | 21207  |                            |
| 5. SEX  | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>    | 8. DATE OF BIRTH | 9. AGE (In years last birthday)  | If Under 1 Yr. Months Days |
| MALE  | WHITE   | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                       | 2-13-1888        | 81   |                            |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |         | 10B. KIND OF BUSINESS OR INDUSTRY  |                  | 11. BIRTHPLACE (State or foreign country)                                |                            |
| CUSTODIAN - BALTO COUNTY  |         |  |                  | WAYNESBORO VA.   |                            |
| 12. CITIZEN OF WHAT COUNTRY?  |         | USA  |                  |  |                            |
| 13. FATHER'S NAME   |         | 14. MOTHER'S MAIDEN NAME   |                  |  |                            |
| WILLIAM CRIZER  |         | HILDEBRAND   |                  |  |                            |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |         | 16. SOCIAL SECURITY NO.  |                  | 17. INFORMANT ADDRESS  |                            |
| NO  |         |  |                  | Ella M. Crizer - 3801 Gwynn Oak Avenue                                   |                            |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |         | CAUSE OF DEATH   |                  |  |                            |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)   |         | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                      |                  |  |                            |
|   |         | Coronary Vascular Disease  |                  |  |                            |
|   |         | (B) DUE TO, OR AS A CONSEQUENCE OF:  |                  |  |                            |
| ANTECEDENT CAUSES   |         | Arterio Sclerosis  |                  |  |                            |
|   |         | (C) DUE TO, OR AS A CONSEQUENCE OF:  |                  |  |                            |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |         | Diabetes Mellitus  |                  |  |                            |
|   |         | (D) DUE TO, OR AS A CONSEQUENCE OF:  |                  |  |                            |
| 19A. DATE OF OPERATION  |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                  | 20A. AUTOPSY? (Yes or No)  |                            |
|   |         |  |                  |  |                            |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                            |
|   |         |  |                  |  |                            |
| 21D. TIME OF INJURY (APPROX.)   |         | 21E. INJURY OCCURRED   |                  | 21F. HOW DID INJURY OCCUR?   |                            |
|   |         | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |                  |  |                            |
| 22. I certify that (1) (this hospital) attended the deceased from 19 64 to 19 69, that (1) (we) last saw the deceased alive on 10-30-69 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. |         |  |                  |  |                            |
| 23A. SIGNATURE  |         | 23B. DATE SIGNED   |                  |  |                            |
| David I. Miller M.D.  |         | 10-31-69   |                  |  |                            |
| 23C. PHYSICIAN'S NAME (Type)  |         | 23D. ADDRESS   |                  |  |                            |
| David I. Miller M.D.  |         | 9115 Reisterstown Rd. Owings Mills, Md.  |                  |  |                            |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |         | 24B. DATE  |                  | 24C. NAME OF CEMETERY or CREMATORY                                       |                            |
| BURIAL  |         | 11-3-69  |                  | LAKEVIEW CEMETERY  |                            |
|   |         |  |                  | HOLBROOK, MARYLAND   |                            |
| 25A. DATE REC'D BY HEALTH DEPT.   |         | 25B. NAME OF REGISTRAR   |                  | 25C. FUNERAL DIRECTOR ADDRESS  |                            |
| NOV 3 1969  |         | Robert S. Taylor, Jr.  |                  | Armagost Funeral Chapel 4600 Liberty Hts.                                |                            |



## FUNERAL DIRECTOR: IMPORTANT

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| BALTIMORE CITY HEALTH DEPARTMENT   |  |   |  | REG. NO. 69 10747   |  |
|--|--|---|--|---|--|
| 0-315  |  |   |  | 69 10747  |  |
| BIRTH NO.  |  |   |  | CERTIFICATE OF DEATH  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Helen Ottaviano</u>  |  |   | 2. DATE AND HOUR OF DEATH<br><u>10-30-69</u> <u>12:15</u> P.M.                                   |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)            |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>31</u> <u>Baltimore City Hospitals</u><br><u>4940 Eastern Avenue</u><br><u>Baltimore, Maryland 21224</u>  |  |   | A. STATE <u>Maryland</u><br>B. COUNTY <u>26</u>  |   |  |
| 5. SEX <u>Female</u>   |  |   | 6. RACE <u>White</u>   |   |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   |  |   | 8. DATE OF BIRTH <u>7-22-1889</u>  |   |  |
| WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |   | 9. AGE (In years last birthday) <u>80</u>  |   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress</u>  |  |   | 10B. KIND OF BUSINESS OR INDUSTRY <u>Resturant</u>   |   |  |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>  |  |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |   |  |
| 13. FATHER'S NAME <u>**-----</u> <u>Burch</u>  |  |   | 14. MOTHER'S MAIDEN NAME <u>Shara</u>  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>   |  |   | 16. SOCIAL SECURITY NO. <u>217-18-2771A</u>  |   |  |
| 17. INFORMANT <u>Records: BCH-4940 Eastern Avenue</u>  |  |   | ADDRESS <u>21224</u>   |   |  |
| 18. <u>412.4 I</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><u>ASCVD</u><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>II</u><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br>19A. DATE OF OPERATION <u>0</u><br>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>20A. AUTOPSY? (Yes or No) <u>No</u><br>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>20 yrs.</u>                                   |   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |  |   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)         |   |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |   | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |   |  |
| 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  |   | 21F. HOW DID INJURY OCCUR?   |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9-9-69</u> to <u>10-30-69</u> that (I) (we) last saw the deceased alive on <u>10-30-69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |  |   |  |   |  |
| 23A. SIGNATURE <u>G.W. Gragg, M.D.</u>   |  |   | 23B. DATE SIGNED <u>10-30-69</u>   |   |  |
| 23C. PHYSICIAN'S NAME (Type) <u>G.W. Gragg</u>   |  |   | 23D. ADDRESS <u>Baltimore City Hospitals</u><br><u>4940 Eastern Avenue, Baltimore, Md. 21224</u> |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 24B. DATE <u>10-31-69</u>                         |  | 24C. NAME of CEMETERY or CREMATORY <u>Mt. Olivet Cemetery</u> |  |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>   |  | 25A. DATE REC'D BY HEALTH DEPT. <u>NOV 3 1969</u> |  |   |  |
| 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>   |  | 25C. FUNERAL DIRECTOR <u>William E. Johnson</u>   |  |   |  |
| 25D. ADDRESS <u>8521 Loch Raven Blvd.</u>  |  |   |  |   |  |





B-415

69 10748

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 10748

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

GILBERT BLEVINS

2. DATE  
OF  
DEATHKnown ☒  
Estimated ☐

Month

Day

Year

Hour

10

31

1969

3:45a

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

Oct.

31.

1969

3:45 a

M.

FULL NAME OF  
HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

City Hospital

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

5300

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Middle River 21220

D. INSIDE CITY LIMITS?

YES ☐NO ☒

9. DATE OF BIRTH

1925

10. AGE (In years  
lost birthday)

44

If Under 1 Yr. If Under 24 Hrs.  
Months, Days, Hours, Min.

E. STREET AND NUMBER

109 Kingston Rd.

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

William T. Blevins

14. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Shipper

14B. KIND OF BUSINESS OR INDUSTRY

Westinhouse Corp.

15. MOTHER'S MAIDEN NAME

Lucy E. Hess

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWII

17. SOCIAL  
SECURITY NO.

230 18 2697

18. INFORMANT

Wife

Helen Blevins

Same

ADDRESS

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME  
OF INJURY  
(APPROX.)

(Month)

(Day)

(Year)

(Hour)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Isidore Mihalakis, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/31/69

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Removal

24B. DATE

11/1/69

24C. NAME of CEMETERY or CREMATORY

Henderson Funeral Chapel

24D. LOCATION

(City, town, or county)

(State)

Abingdon, Va.

25A. DATE REC'D BY HEALTH DEPT.

NOV 3 1969

25B. NAME OF REGISTRAR

Robert E. Fahren, M.D.

25C. FUNERAL DIRECTOR

Bruzdzinski Funeral Home

ADDRESS

1407 Eastern Ave.

11/12/69 - Correction form from funeral director.

*ABC.*

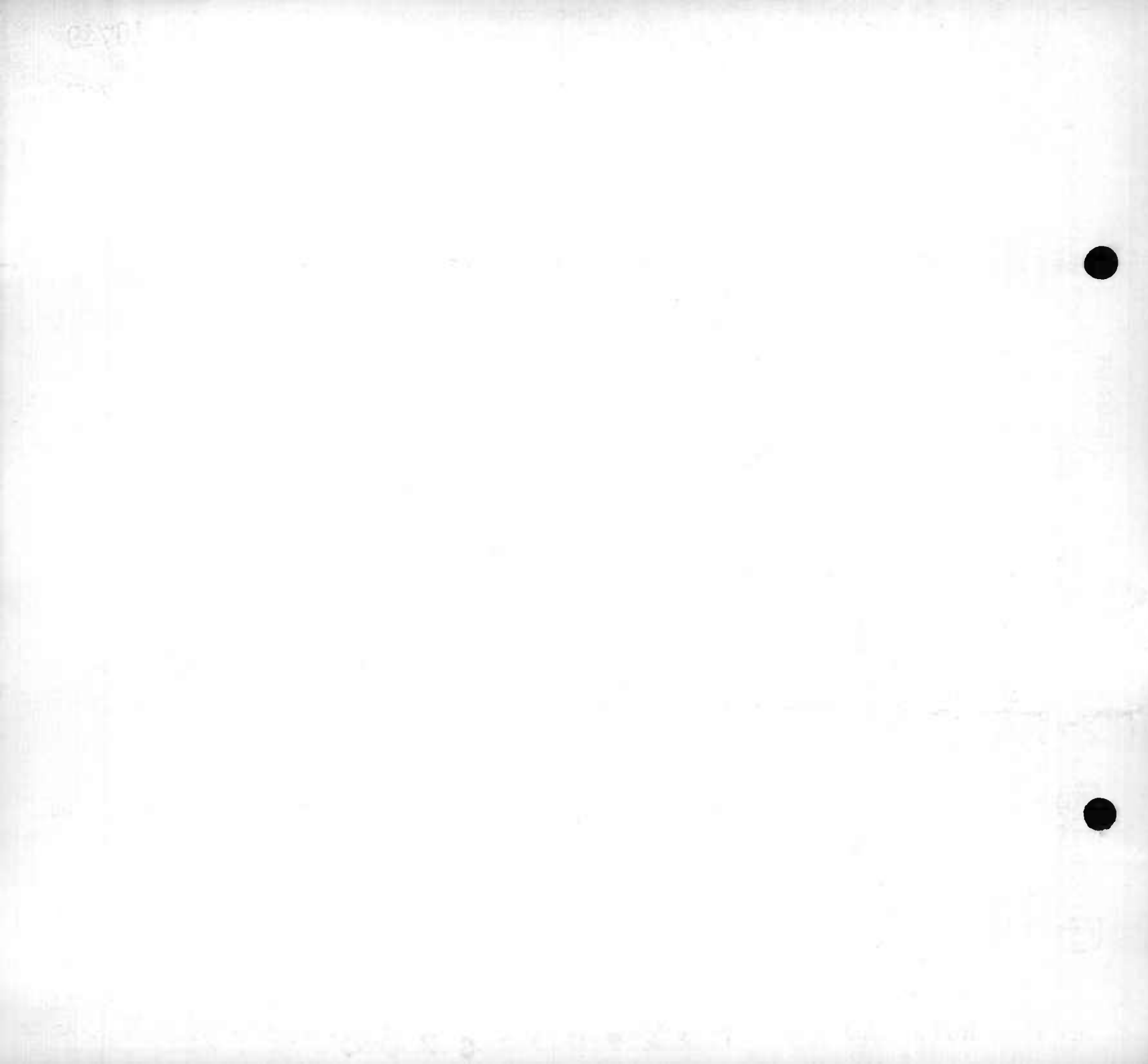
CERTIFICATE AMENDED

VALLEY VIEW  
VALLEY VIEW

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

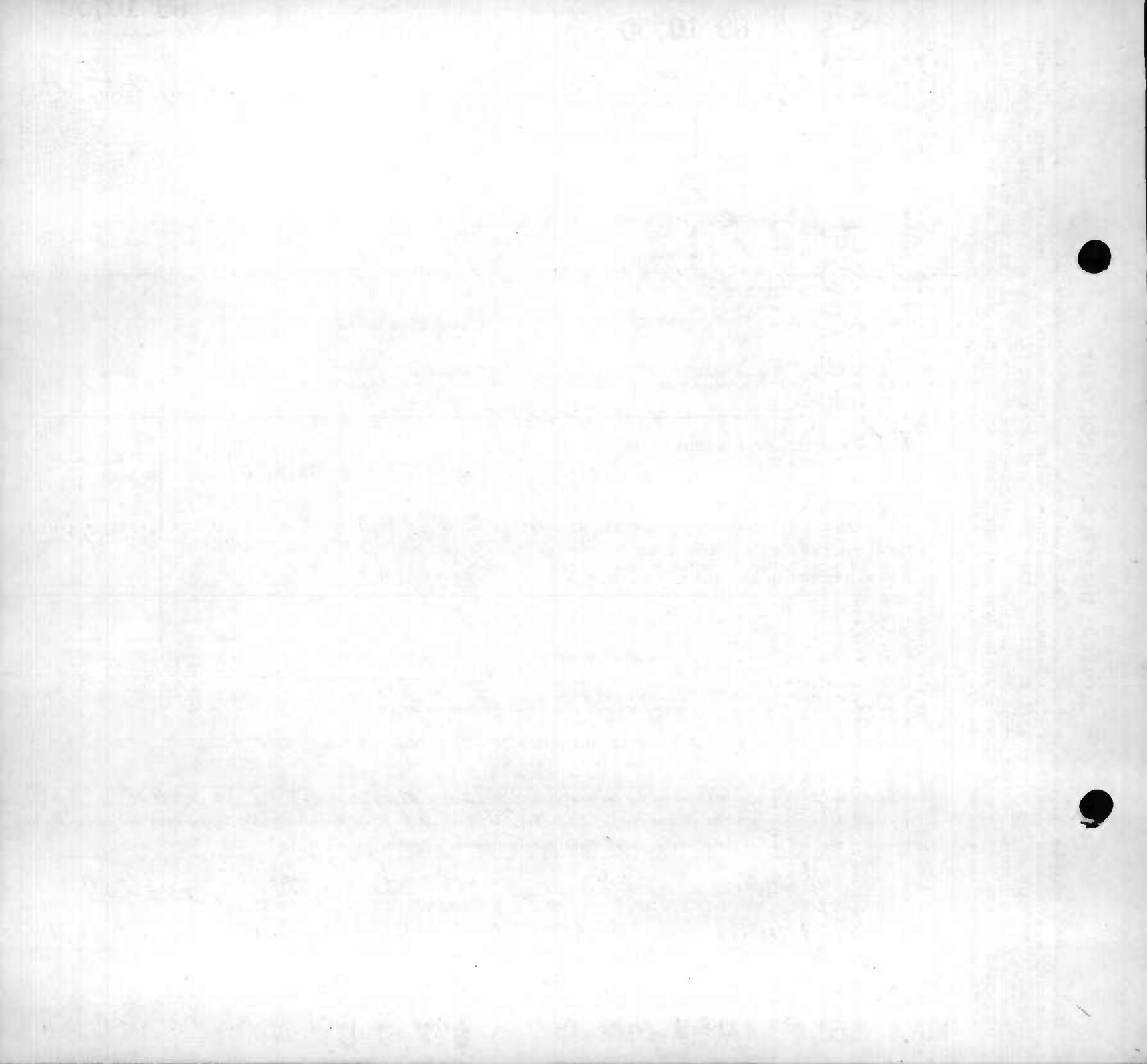
| BALTIMORE CITY HEALTH DEPARTMENT   |                         |  |                                      | REG. NO. <u>69 10749</u>   |
|--|-------------------------|--|--------------------------------------|--|
| BIRTH NO. <u>9-620</u>   |                         | <b>69 10749 CERTIFICATE OF DEATH</b>   |                                      |  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>RUARK, VIRGIE P.</u>   |                         | 2. DATE AND HOUR OF DEATH<br><u>10-31-69 - 9:00 P.M.</u>   |                                      |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                         | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  |                                      |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>SOUTH BALTIMORE GEN. HOSP.</u><br><u>43</u>   |                         | A. STATE <u>MD.</u><br>B. COUNTY <u>2402</u>   |                                      |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |                         | C. CITY OR TOWN<br><u>BALTO.</u>   |                                      | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                         |
|  |                         | E. STREET AND NUMBER<br><u>414 E. CLEMENT ST</u>   |                                      |  |
| 5. SEX<br><u>F.</u>  | 6. RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><u>9-10-1895</u> | 9. AGE (in years last birthday) <u>74</u>  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Home</u>   |                                      | 11. BIRTHPLACE (State or foreign country)<br><u>MD.</u>  |
| 13. FATHER'S NAME<br><u>CHAS. G. TRAVERS</u>   |                         | 14. MOTHER'S MAIDEN NAME<br><u>Winnie (Simmons)</u>  |                                      |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No.</u>   |                         | 16. SOCIAL SECURITY NO.<br><u>                    </u>   |                                      | 17. INFORMANT<br><u>Herman Ruark</u>   |
|  |                         |  |                                      | ADDRESS<br><u>405 Holy Cross Rd. 21225</u>   |
| 18. <u>183.0 I</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, oshterio, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                         | CAUSE OF DEATH<br><u>Metastatic</u><br><u>TERMINAL CA.</u><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><u>PRIMARY</u><br>(B) <u>OVARIAN CA.</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <u>                    </u> |                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>                    </u>                                |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |                         |  |                                      |  |
| 19A. DATE OF OPERATION<br><u>0</u>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>                    </u>  |                                      | 20A. AUTOPSY? (Yes or No)<br><u>                    </u>   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><u>                    </u>  |                                      | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)<br><u>                    </u> |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)<br><u>                    </u>   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                                      | 21F. HOW DID INJURY OCCUR?<br><u>                    </u>  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>SEPT. 2, 1969</u> to <u>OCT. 31, 1969</u> that (I) (we) lost saw the deceased alive on <u>OCT. 31, 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.              |                         |  |                                      |  |
| 23A. SIGNATURE<br><u>Alfredo B. Caragay, M.D.</u>  |                         | 23B. DATE SIGNED<br><u>10-31-69</u>  |                                      |  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>ALFREDO B. CARAGAY</u>  |                         | 23D. ADDRESS<br><u>SOUTH BALTIMORE GEN. HOSP.</u>  |                                      |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |                         | 24B. DATE<br><u>11-3-69</u>  |                                      | 24C. NAME OF CEMETERY OR CREMATORY<br><u>Glen Haven Cemetery</u>   |
| 24D. LOCATION<br><u>Glen Burnie Md.</u>  |                         |  |                                      |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 3 1969</u>   |                         | 25B. NAME OF REGISTRAR<br><u>Robert E. Talley, M.D.</u>  |                                      | 25C. FUNERAL DIRECTOR<br><u>McGulley - 130 E. Fort Ave. 21230</u>  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                  |   |                              |   |   |
|--|------------------|---|------------------------------|---|---|
| BIRTH NO.  |                  | BALTIMORE CITY HEALTH DEPARTMENT  |                              | REG. NO. 475  |   |
| 1. NAME OF DECEASED<br>(Type or Print)<br>CHARLOTTE M. MILLER  |                  | 2. DATE AND HOUR OF DEATH<br>Oct 22, 1969 2:15 A.M.   |                              |   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                  | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE Md. B. COUNTY 2006  |                              |   |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>Park Hill Convalescent Home  |                  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |                              | C. CITY OR TOWN<br>BALTO  |   |
|  |                  |   |                              | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
|  |                  |   |                              | E. STREET AND NUMBER<br>3311 Edmondson Ave  |   |
| 5. SEX<br>Female   | 6. RACE<br>White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>2/1/1979 | 9. AGE (In years lost birthday)<br>90   | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                  | 10B. KIND OF BUSINESS OR INDUSTRY   |                              | 11. BIRTHPLACE (State or foreign country)   |   |
| 12. CITIZEN OF WHAT COUNTRY?   |                  | 13. FATHER'S NAME   |                              | 14. MOTHER'S MAIDEN NAME  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |                  | 16. SOCIAL SECURITY NO.<br>219-34-2493A   |                              | 17. INFORMANT ADDRESS   |   |
| 18. 412.4 I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)<br>CHF (chronic)   |                  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:  |                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>—   |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                  | (B) ASCVD<br>DUE TO, OR AS A CONSEQUENCE OF:  |                              | sw yrs  |   |
|  |                  | (C) Emphysema   |                              | " "   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                  |   |                              |   |   |
| 19A. DATE OF OPERATION   |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                              | 20A. AUTOPSY? (Yes or No) NO  |   |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |                  |   |                              |   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                              | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                              | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) (this hospital) attended the deceased from 29 Mar 1967 to 22 Oct 1969, that (I) (we) last saw the deceased alive on 22 Oct 1969 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                  |   |                              |   |   |
| 23A. SIGNATURE<br>J. Hulla M.D.  |                  | 23B. DATE SIGNED<br>22 Oct 69   |                              | 23C. PHYSICIAN'S NAME (Type)<br>J. Hulla M.D.   |   |
| 23D. ADDRESS<br>2214 E Bay View St   |                  | 23E. CITY, TOWN, OR COUNTY<br>BALTO. MD.  |                              |   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>BURIAL   |                  | 24B. DATE<br>10-24-69   |                              | 24C. NAME OF CEMETERY OR CREMATORY<br>MORELAND MEM.   |   |
| 24D. LOCATION<br>BALTO. MD.  |                  | 24E. DATE REC'D BY HEALTH DEPT.<br>NOV 3 1969   |                              |   |   |
| 24F. NAME OF REGISTRAR<br>O O O  |                  | 24G. FUNERAL DIRECTOR<br>Wm J. Fickner & Sons   |                              | 24H. ADDRESS<br>BALTO. Md.  |   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                         |   |                                   |  |   |
|--|-------------------------|---|-----------------------------------|--|---|
| K-500 69 10751   |                         | BALTIMORE CITY HEALTH DEPARTMENT<br><b>CERTIFICATE OF DEATH</b>   |                                   | REG. NO. 69 10751  |   |
| BIRTH NO.  |                         | 1. NAME OF DECEASED<br>(Type or Print) <b>Justus Kehne, SR.</b>   |                                   | 2. DATE AND HOUR OF DEATH<br><b>10-29-69 4:55 A.M.</b>   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>2609</b>                  |                                   | C. CITY OR TOWN <b>Baltimore</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>90 Dukeland Nursing + Conv Home</b><br><b>1501 Dukeland Street,</b>   |                         | E. STREET AND NUMBER<br><b>707 S Highland Ave, #21224.</b>  |                                   |  |   |
| 5. SEX<br><b>MALE</b>  | 6. RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>7-7-88</b> | 9. AGE (In years last birthday) <b>81</b>  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED</b>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>KUONTZ DIARY Co.</b>  |                                   | 11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b><br>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                  |   |
| 13. FATHER'S NAME<br><b>HENRY KEHNE</b>  |                         | 14. MOTHER'S MAIDEN NAME<br><b>REGINA STEINRUCKEN</b>   |                                   |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>  |                         | 16. SOCIAL SECURITY NO.<br><b>212-10-8664</b>   |                                   | 17. INFORMANT <b>Dukeland nursing home</b><br>ADDRESS <b>1501 Dukeland St.</b>   |   |
| 18. <b>4123 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>CHRONIC MYOCARDITIS E</b><br><b>LEFT VENTRICULAR FAILURE</b>  |                         | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>ASC D</b>   |                                   | (B) DUE TO, OR AS A CONSEQUENCE OF:  |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.<br><b>II</b>  |                         | (C) _____   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |                         |   |                                   |  |   |
| 19A. DATE OF OPERATION   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                   | 20A. AUTOPSY? (Yes or No)  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                                   | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>March 28, 1967</b> to <b>10-29-1969</b> , that (I) (we) last saw the deceased alive on <b>10-29-1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |   |                                   |  |   |
| 23A. SIGNATURE<br><b>Thomas W. Harris, M.D.</b>  |                         | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>                             |                                   | 23B. DATE SIGNED<br><b>10/29/69</b>  |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Thomas W. Harris Jr MD</b>  |                         | 23D. ADDRESS<br><b>4200 Edmondson Ave</b>   |                                   |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                         | 24B. DATE<br><b>11-1-69</b>   |                                   | 24C. NAME OF CEMETERY or CREMATORY<br><b>BALTIMORE CEM.</b>  |   |
| 24D. LOCATION<br><b>E. NORTH AVE., BALTO., MD.</b>   |                         |   |                                   |  |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 3 1969</b>   |                         | 25B. NAME OF REGISTRAR<br><b>Charles B. Seiler</b>  |                                   | 25C. FUNERAL DIRECTOR<br><b>901 S. CONKLING BALTO., 21224, MD</b>  |   |







# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |   |   |
|--|--|---|---|
| G-650  |  | BALTIMORE CITY HEALTH DEPARTMENT  |   |
| 69 10752   |  | CERTIFICATE OF DEATH  |   |
| BIRTH NO.  |  | REG. NO. 69 10752   |   |
| 1. NAME OF DECEASED<br>(Type or Print)   |  | 2. DATE AND HOUR OF DEATH   |   |
| GREEN EDITH  |  | October 30, 1969 3:30 P.M.  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)   |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><br>44 UNION MEMORIAL Hospital   |  | A. STATE<br>MARYLAND  |   |
|  |  | B. COUNTY<br>2765   |   |
| C. CITY OR TOWN<br>BALTIMORE   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |
| E. STREET AND NUMBER<br>4426 BUENA VISTA AVENUE  |  |   |   |
| 5. SEX<br>FEMALE   | 6. RACE<br>WHITE                               | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>09-01-97  |
| 9. AGE (In years last birthday)<br>72  |  | 10. If Under 1 Yr. Months: Days: Hours: Min.  |   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>NONE  |  | 10B. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (State or foreign country)<br>WEST VIRGINIA   |  | 12. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |   |
| 13. FATHER'S NAME<br>J. H. EVANS   |  | 14. MOTHER'S MAIDEN NAME<br>Ida M. McKenzie   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>no   |  | 16. SOCIAL SECURITY NO.<br>213-54-1444  |   |
| 17. INFORMANT<br>Welton A. Green, 4426 Buena Vista Ave.  |  | ADDRESS   |   |
| 18. CAUSE OF DEATH<br>430.0 I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br>ARTERIOSCLEROTIC CARDIOVASCULAR disease |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |
| (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>BRONCHOPNEUMONIA   |  |   |   |
| (B) SUBARACNOID HEMORRHAGE<br>DUE TO, OR AS A CONSEQUENCE OF:  |  |   |   |
| (C) ARTERIAL HYPERTENSION<br>DUE TO, OR AS A CONSEQUENCE OF:   |  |   |   |
| 19A. DATE OF OPERATION<br>O  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |
| 20A. AUTOPSY? (Yes or No)<br>NO  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   |
| 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)  |  |   |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |   |
| 21F. HOW DID INJURY OCCUR?   |  |   |   |
| 22. I certify that (X) (this hospital) attended the deceased from October 19 69 to October 30 19 69 that (X) (we) last saw the deceased alive on October 30 19 69 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.  |  |   |   |
| 23A. SIGNATURE<br>Miguel Karacuschansky M.D.   |  | 23B. DATE SIGNED<br>October 30, 1969  |   |
| 23C. PHYSICIAN'S NAME (Type)<br>Miguel KARACUSCHANSKY M.D.   |  | 23D. ADDRESS<br>UNION MEMORIAL Hospital   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial   | 24B. DATE<br>11/3/69                           | 24C. NAME OF CEMETERY OR CREMATORY<br>St. Mary's Cem.-Hampden   | 24D. LOCATION (City, town, or county) (State)<br>Roland Ave., Balto., Md. |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 3 1969  | 25B. NAME OF REGISTRAR<br>Jabob E. Jabob, M.D. | 25C. FUNERAL DIRECTOR ADDRESS<br>Ann Donovan - 3818 Roland Ave.   |   |

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18-01 18 32

X

18-01 18 32

18-01 18 32

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |   |  |   |
|---|---|--|---|
| 69 10753  |   | CERTIFICATE OF DEATH   |   |
| B-200   |   | REG. NO. 69 10753  |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>NELLIE P BUCK (NELLIE PARKINS BUCK)</b>   |   | 2. DATE AND HOUR OF DEATH<br><b>1 NOVEMBER 69</b> <b>150 A M.</b>  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |   | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <b>MD</b> B. COUNTY <b>—</b> |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>UNION MEMORIAL HOSPITAL</b>  |   | C. CITY OR TOWN<br><b>BALTIMORE</b>  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX <b>Female</b> 6. RACE <b>White</b>   |   | E. STREET AND NUMBER<br><b>BROADVIEW APTS #10</b>  |   |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |   | 8. DATE OF BIRTH<br><b>April 30, 1887</b>  |   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>   |   | 9. AGE (In years last birthday)<br><b>82</b>   |   |
| 10B. KIND OF BUSINESS OR INDUSTRY<br><b>— NONE</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>KANSAS</b>   |   |
| 13. FATHER'S NAME<br><b>Alfred Parkins</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |   |
| 16. SOCIAL SECURITY NO.<br><b>220-44-3714J</b>  |   | 17. INFORMANT: daughter<br><b>Alice Buck Bramble, 205 Tunbridge Rd. (12)</b>   |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>METASTATIC CARCINOMA OF LUNGS</b>   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>?</b>   |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b>   |   | (B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>CONGESTION HEART FAILURE</b>   |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>CONGESTION HEART FAILURE</b>   |   | 2 DAYS   |   |
| 19A. DATE OF OPERATION<br><b>0</b>  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20A. AUTOPSY? (Yes or No)  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)          | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that <b>Dr. (thel hospital)</b> attended the deceased from <b>30 OCT</b> 19 <b>69</b> to <b>1 NOV</b> 19 <b>69</b> that (I) <b>(not)</b> last saw the deceased alive on <b>31 OCT</b> 19 <b>69</b> and that (in my) <b>(not)</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>(not)</b> (did) <b>(not)</b> view the body after death. |   |  |   |
| 23A. SIGNATURE<br><b>J. Dixon H. H. S.</b>  |   | 23B. DATE SIGNED<br><b>1 Nov 69</b>  |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>J. Dixon H. H. S.</b>  |   | 23D. ADDRESS<br><b>3501 ST. PAUL ST. BALTIMORE 18</b>  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  | 24B. DATE<br><b>11/3/69</b>   | 24C. NAME of CEMETERY or CREMATORY<br><b>Green Mount Cemetery</b>  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>                   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 3 1969</b>  |   | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor</b>  |   |
| 25C. FUNERAL DIRECTOR<br><b>Stewart &amp; Mollen Co.</b>  |   | ADDRESS<br><b>108 W. North Av. 21201</b>   |   |

116 W University Drwy.

H-322

69 10754 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 10754

BIRTH NO.

|  |                         |  |  |   |  |   |  |
|--|-------------------------|--|--|---|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>ROBERT W. HODGES</b>   |                         |  |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month <b>10</b> Day <b>25</b> Year <b>69</b> Hour <b>11:27</b> a <b>M.</b><br>Estimated <input type="checkbox"/>        |  |   |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Franklin Square Hospital D.O.A.</b><br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |                         |  |  | 3. DATE PRONOUNCED DEAD<br>Month <b>Oct.</b> Day <b>25</b> Year <b>1969</b> Hour <b>11:27</b> a <b>M.</b>   |  |   |  |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>1902</b>  |                         |  |  |   |  |   |  |
| 6. SEX<br><b>Male</b>  | 7. RACE<br><b>White</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | C. CITY OR TOWN<br><b>Balto.</b>  |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 9. DATE OF BIRTH<br><b>Apr 2, 1916</b>   |                         | 10. AGE (In years last birthday)<br><b>53</b>  |  | E. STREET AND NUMBER<br><b>39 S. Stricker St.</b>   |  |   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>   |                         | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 13. FATHER'S NAME<br><b>Harry J. Hodges</b>   |  |   |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Lithographer</b>   |                         | 14B. KIND OF BUSINESS OR INDUSTRY<br><b>Printing</b>   |  | 15. MOTHER'S MAIDEN NAME<br><b>Florence V. Thomas</b>   |  |   |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  |                         | 17. SOCIAL SECURITY NO.  |  | 18. INFORMANT<br><b>Harry Hodges, Jr.</b>   |  | ADDRESS   |  |
| 19. <b>E955 X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                         |  |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br><b>Gunshot wound of the forehead</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) _____<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) _____ |  |   |  |
| 20A. DATE OF OPERATION<br><b>0</b>   |                         |  |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 21. AUTOPSY? (Yes or No)<br><b>NO</b>   |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                         | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Home</b>  |  | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br><b>Bedroom 39 S. Stricker St. 1902</b>  |  |   |  |
| 22D. TIME OF INJURY (APPROX.)<br><b>10 25 69 11:00</b>   |                         | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                             |  | 22F. HOW DID INJURY OCCUR?<br><b>Self inflicted gunshot wound</b>   |  |   |  |
| 23.<br>I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br><br>ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Tsodore Mihalakis, M.D.</b><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED <b>Oct. 26, 1969</b> |                         |  |  |   |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 24B. DATE<br><b>10/29/69</b>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Cedar Hill Cemetery</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Suitland, Md.</b>                         |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 3 1969</b>   |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher, M.D.</b>  |  | 25C. FUNERAL DIRECTOR<br><b>Fairley-Coronang</b>  |  | ADDRESS<br><b>11 Catorville</b>   |  |

62-10734

62-10734

W/100-112

2000-11-12

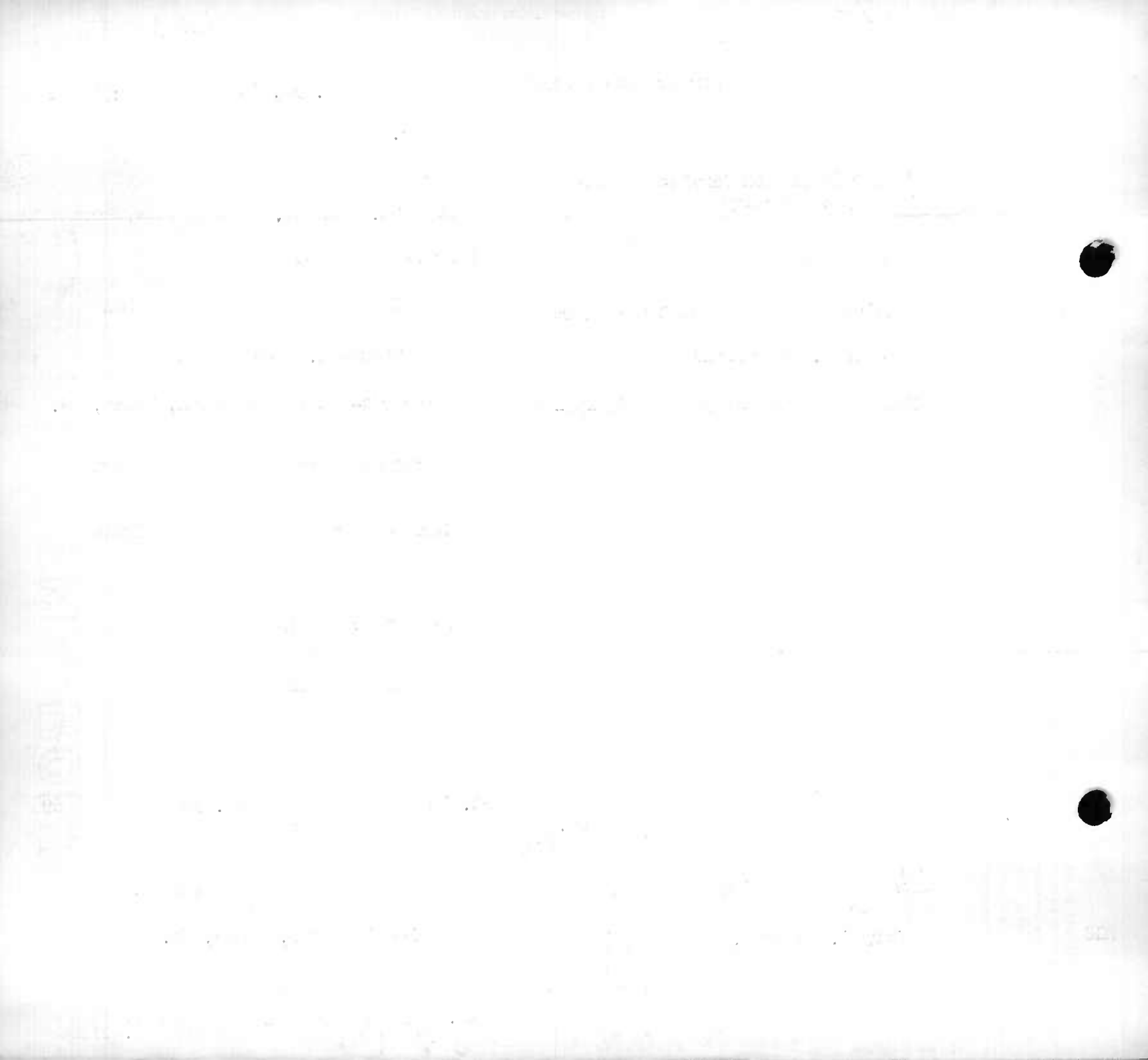
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62-10734

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB

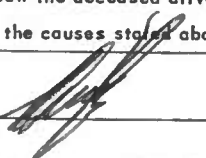
|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| M-235   |  | 69 10755   |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | REG. NO. 69 10755  |  |
| BIRTH NO.   |  |  |  | 1. NAME OF DECEASED<br>(Type or Print)   |  |  |  |
|   |  |  |  | Edwin Herbert Mac Donald   |  |  |  |
| 2. DATE AND HOUR OF DEATH   |  |  |  | Oct. 30, 1969 5:30 P.M.  |  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |  |  |  | A. STATE Md. 8. COUNTY 1205  |  |  |  |
| US Public Health Service Hospital<br>3100 Wyman Parkway   |  |  |  | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                     |  |  |  |
| E. STREET AND NUMBER  |  |  |  | 1703 St. Paul St.  |  |  |  |
| 5. SEX M W  |  | 6. RACE  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH 3/19/04   |  |
|   |  |  |  | 9. AGE (In years last birthday) 65   |  | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.               |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  |  |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| Retired   |  |  |  | US Coast Guard   |  |  |  |
| 11. BIRTHPLACE (State or foreign country)   |  |  |  | 12. CITIZEN OF WHAT COUNTRY?   |  |  |  |
| NY  |  |  |  | USA  |  |  |  |
| 13. FATHER'S NAME   |  |  |  | 14. MOTHER'S MAIDEN NAME   |  |  |  |
| John A. Mac Donald  |  |  |  | Frances A. Wade  |  |  |  |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |  |  |  | 16. SOCIAL SECURITY NO.  |  |  |  |
| Yes CG 1930-1955  |  |  |  | 216-36-0895  |  |  |  |
| 17. INFORMANT   |  |  |  | ADDRESS  |  |  |  |
| Records- US PHS Hospital, Balto, Md.  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH  |  |  |  |  |  |  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |  |  |  |  |  |  |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  |  |  |  |  |  |  |  |
| ANTECEDENT CAUSES   |  |  |  |  |  |  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |  |  |  |  |  |  |  |
| (A) IMMEDIATE CAUSE   |  |  |  |  |  |  |  |
| Hepatic failure   |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF:   |  |  |  |  |  |  |  |
| (B)   |  |  |  |  |  |  |  |
| Cirrhosis of liver  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF:   |  |  |  |  |  |  |  |
| (C)   |  |  |  |  |  |  |  |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |  |  |  |  |
| Weeks   |  |  |  |  |  |  |  |
| Years   |  |  |  |  |  |  |  |
| Subdural hematoma   |  |  |  |  |  |  |  |
| Weeks   |  |  |  |  |  |  |  |
| II  |  |  |  |  |  |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |  |  |  |  |  |  |
| 19A. DATE OF OPERATION  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 2   |  |  |  | yes  |  | yes  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |  |  |
|   |  |  |  |  |  |  |  |
| 21D. TIME OF INJURY (APPROX.)   |  | 21E. INJURY OCCURRED   |  | 21F. HOW DID INJURY OCCUR?   |  |  |  |
| (Month) (Day) (Year) (Hour)   |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |  |  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from Oct. 22 19 69 to Oct. 30 19 69 that (I) (we) last saw the deceased alive on Oct. 30 1969 and that (in my/our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 23A. SIGNATURE  |  |  |  | 23B. DATE SIGNED   |  |  |  |
| Gary E. Feldman, M.D.   |  |  |  | 10/31/69   |  |  |  |
| 23C. PHYSICIAN'S NAME (Type)  |  |  |  | 23D. ADDRESS   |  |  |  |
| Gary E. Feldman, SA Surg (R)  |  |  |  | US PHS Hospital, Balto, Md.  |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |  | 24B. DATE  |  | 24C. NAME of CEMETERY or CREMATORY   |  | 24D. LOCATION (City, town, or county) (State)                        |  |
| Burial  |  | 11-3-1969  |  | Baltimore National   |  | Baltimore, Maryland  |  |
| 25A. DATE REC'D BY HEALTH DEPT.   |  | 25B. NAME OF REGISTRAR   |  | 25C. FUNERAL DIRECTOR  |  |  |  |
| NOV 3 1969  |  | Robert E. Taylor, Jr.  |  | Wm. Cook-Brooks Towson, 1050 York Road Towson, Md. 21204   |  |  |  |

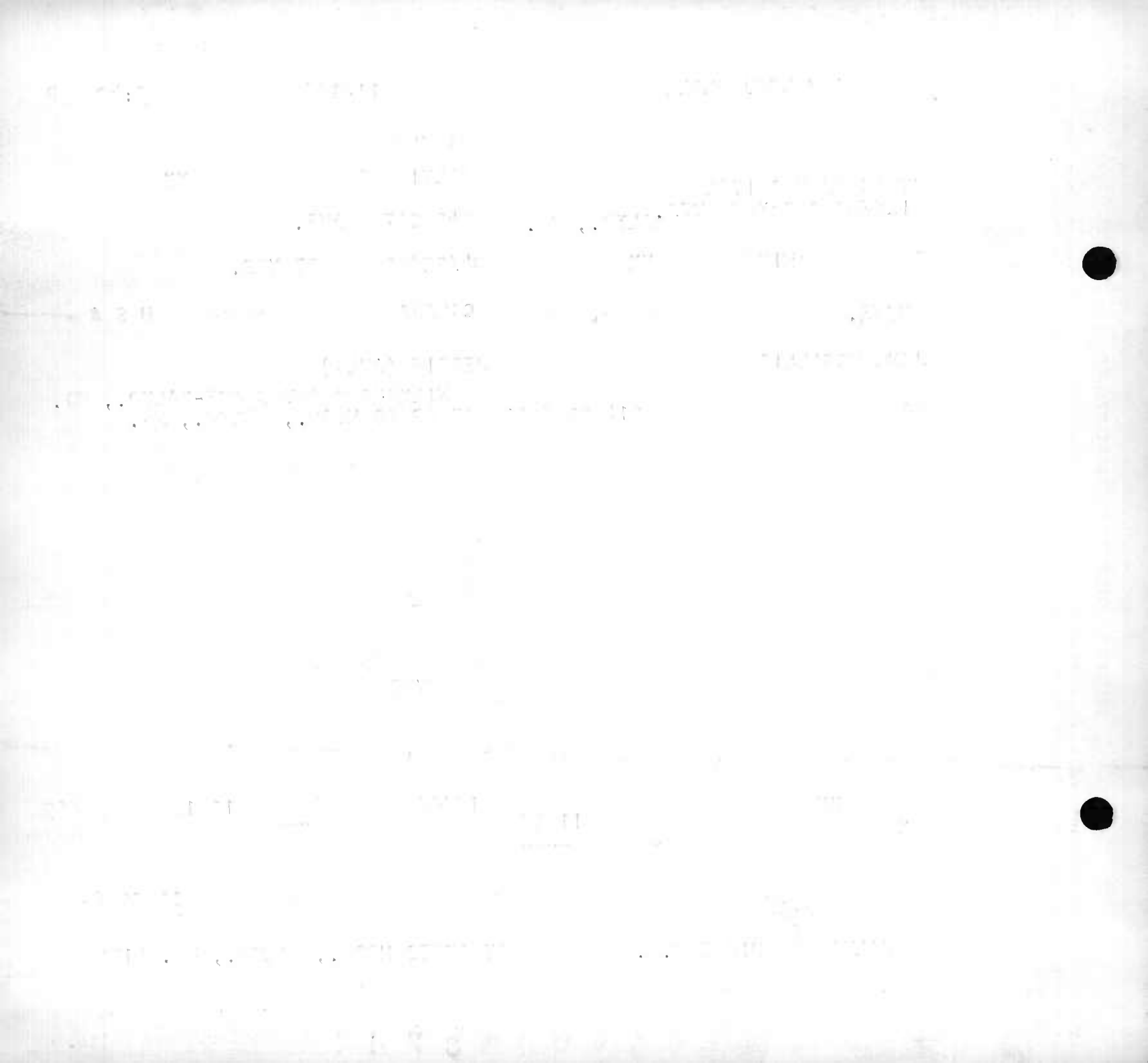




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |   |   |   |
|---|---|---|---|
| BALTIMORE CITY HEALTH DEPARTMENT  |   | REG. NO. <b>69 10756</b>  |   |
| BIRTH NO. <b>69 10756</b>   |   | CERTIFICATE OF DEATH  |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>MARY MENDENHALL</b>   |   | 2. DATE AND HOUR OF DEATH<br><b>11/1/69 5:40 P.M.</b>   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)   |   |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>ST AGNES HOSPITAL<br/>WILKENS &amp; CATON AVES. BALTO., MD.</b>   |   | A. STATE <b>MARYLAND</b><br>B. COUNTY <b>901</b>  |   |
|   |   | C. CITY OR TOWN<br><b>BALTIMORE</b>   | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|   |   | E. STREET AND NUMBER<br><b>942 CATON AVE.</b>   |   |
| 5. SEX<br><b>F</b>  | 6. RACE<br><b>WHITE</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>04/25/92</b>   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HSWF. Saleslady</b>   |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Department Store</b>  | 9. AGE (In years last birthday)<br><b>77 YRS.</b>   |
| 11. BIRTHPLACE (State or foreign country)<br><b>CANADA</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  |   |
| 13. FATHER'S NAME<br><b>JOHN MCGILLIS</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>JESSIE (AULD)</b>  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |   | 16. SOCIAL SECURITY NO.<br><b>214 22 6927</b>   |   |
| 17. INFORMANT<br><b>WILKENS &amp; CATON AVE-BALTO., MD.<br/>ST AGNES HOSP., BALTO., MD.</b>   |   | ADDRESS   |   |
| 18. <b>160.9</b> I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>Generalized Metastasis</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Undifferentiated Carcinoma Right paranasal Sinuses -</b> |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |   |   |   |
| 19A. DATE OF OPERATION<br><b>2</b>  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20A. AUTOPSY? (Yes or No)<br><b>YES</b>   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>10/6/69</b> to <b>11/1/69</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>11/1/69</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (not) view the body after death.    |   |   |   |
| 23A. SIGNATURE<br>   |   | 23B. DATE SIGNED<br><b>11 02 69</b>   |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>SALVADOR QUIROZ M.D.</b>   |   | 23D. ADDRESS<br><b>ST AGNES HOSP., BALTO., MD. 21229</b>  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 24B. DATE<br><b>11/4/69</b>   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>                        |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 3 1969</b>  | 25B. NAME OF REGISTRAR<br><b>Eugenia K. Seitz</b>   | 25C. FUNERAL DIRECTOR<br><b>Eugenia K. Seitz 5209 York Road Balto.-MD</b>   |   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |  |  |   |  |  |  |                                 |  |
|--|--|--|--|---|--|--|--|---------------------------------|--|
| H-320  |  | 69 10757   |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | X  |  | 69 10757                        |  |
| BIRTH NO.  |  | 1. NAME OF DECEASED<br>(Type or Print)   |  |   |  | 2. DATE AND HOUR OF DEATH  |  |                                 |  |
|  |  | HETTCHÉ, ROBERT JOHN   |  |   |  | NOVEMBER 1, 1969 4:25A   |  |                                 |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)    |  |   |  |  |  |                                 |  |
| FULL NAME OF HOSPITAL OR INSTITUTION   |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                     |  |   |  | A. STATE & COUNTY  |  |                                 |  |
| 40 ST AGNES HOSPITAL   |  |  |  |   |  | MARYLAND DD CO. 5200   |  |                                 |  |
|  |  |  |  |   |  | C. CITY OR TOWN  |  |                                 |  |
|  |  |  |  |   |  | PASADENA   |  |                                 |  |
|  |  |  |  |   |  | D. INSIDE CITY LIMITS?   |  |                                 |  |
|  |  |  |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>             |  |                                 |  |
|  |  |  |  |   |  | E. STREET AND NUMBER   |  |                                 |  |
|  |  |  |  |   |  | 201 HILLCREST ROAD   |  |                                 |  |
| 5. SEX   |  | 6. RACE  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  | 8. DATE OF BIRTH   |  | 9. AGE (In years last birthday) |  |
| MALE   |  | WHITE  |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |  | 09 24 04   |  | 65                              |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)   |  | 12. CITIZEN OF WHAT COUNTRY?   |  |                                 |  |
| RETIRED-FOREMAN  |  | ATLANTIC TERM  |  | NAL MARYLAND  |  | U S A  |  |                                 |  |
| 13. FATHER'S NAME  |  |  |  | 14. MOTHER'S MAIDEN NAME  |  |  |  |                                 |  |
| JOHN HETTCHÉ   |  |  |  | ANNA KIRCHWEHN  |  |  |  |                                 |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                   |  |  |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |                                 |  |
| NO   |  |  |  | 215015433   |  | ST AGNES RECORDS-BALTO MD 21229                                      |  |                                 |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH   |  | CAUSE OF DEATH   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                         |  |                                 |  |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                      |  |   |  | Myocardial infarction, recent  |  |                                 |  |
| ANTECEDENT CAUSES  |  | (B) DUE TO, OR AS A CONSEQUENCE OF:  |  |   |  | arterio-sclerotic cardiovascular disease                             |  |                                 |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                  |  | (C) DUE TO, OR AS A CONSEQUENCE OF:  |  |   |  |  |  |                                 |  |
| II   |  |  |  |   |  |  |  |                                 |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).           |  |  |  |   |  |  |  |                                 |  |
| 19A. DATE OF OPERATION   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                                 |  |
| 29 Sep. 69   |  | subtotal gastrectomy   |  | YES   |  |  |  |                                 |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |  |  |  |                                 |  |
| 21D. TIME OF INJURY (APPROX.)  |  | 21E. INJURY OCCURRED   |  | 21F. HOW DID INJURY OCCUR?  |  |  |  |                                 |  |
| (Month) (Day) (Year) (Hour)  |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |  |   |  |  |  |                                 |  |
| 22. I certify that (X) (this hospital) attended the deceased from  |  | OCTOBER 25   |  | 1969  |  | to   |  | NOVEMBER 1 1969                 |  |
| that (X) (we) last saw the deceased alive on   |  | NOVEMBER 1   |  | 19 69   |  | and that (in my) (our) opinion death occurred on the date            |  |                                 |  |
| and hour and from the causes stated above.   |  | XX (we) (did) (did not) view the body after death.                                       |  |   |  |  |  |                                 |  |
| 23A. SIGNATURE   |  | 23B. DATE SIGNED   |  | 23C. PHYSICIAN'S NAME (Type)  |  | 23D. ADDRESS   |  |                                 |  |
| Joe-Shiung Wu  |  | 11/1/69  |  | TSE-SHIUNG WU   |  | BALTO. MD 21229  |  |                                 |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |  | 24B. DATE  |  | 24C. NAME OF CEMETERY OR CREMATORY  |  | 24D. LOCATION (City, town, or county) (State)                        |  |                                 |  |
| Burial   |  | NOV. 4-69  |  | PARKWOOD CEMETERY   |  | BALTO. 21219, MARYLAND   |  |                                 |  |
| 25A. DATE REC'D BY HEALTH DEPT.  |  | 25B. NAME OF REGISTRAR   |  | 25C. FUNERAL DIRECTOR   |  | ADDRESS  |  |                                 |  |
| NOV 3 1969   |  | Robert E. Taylor, M.D.   |  | J. H. HAHN, JR.   |  | 200 PENNINGTON AVE   |  | 21226                           |  |

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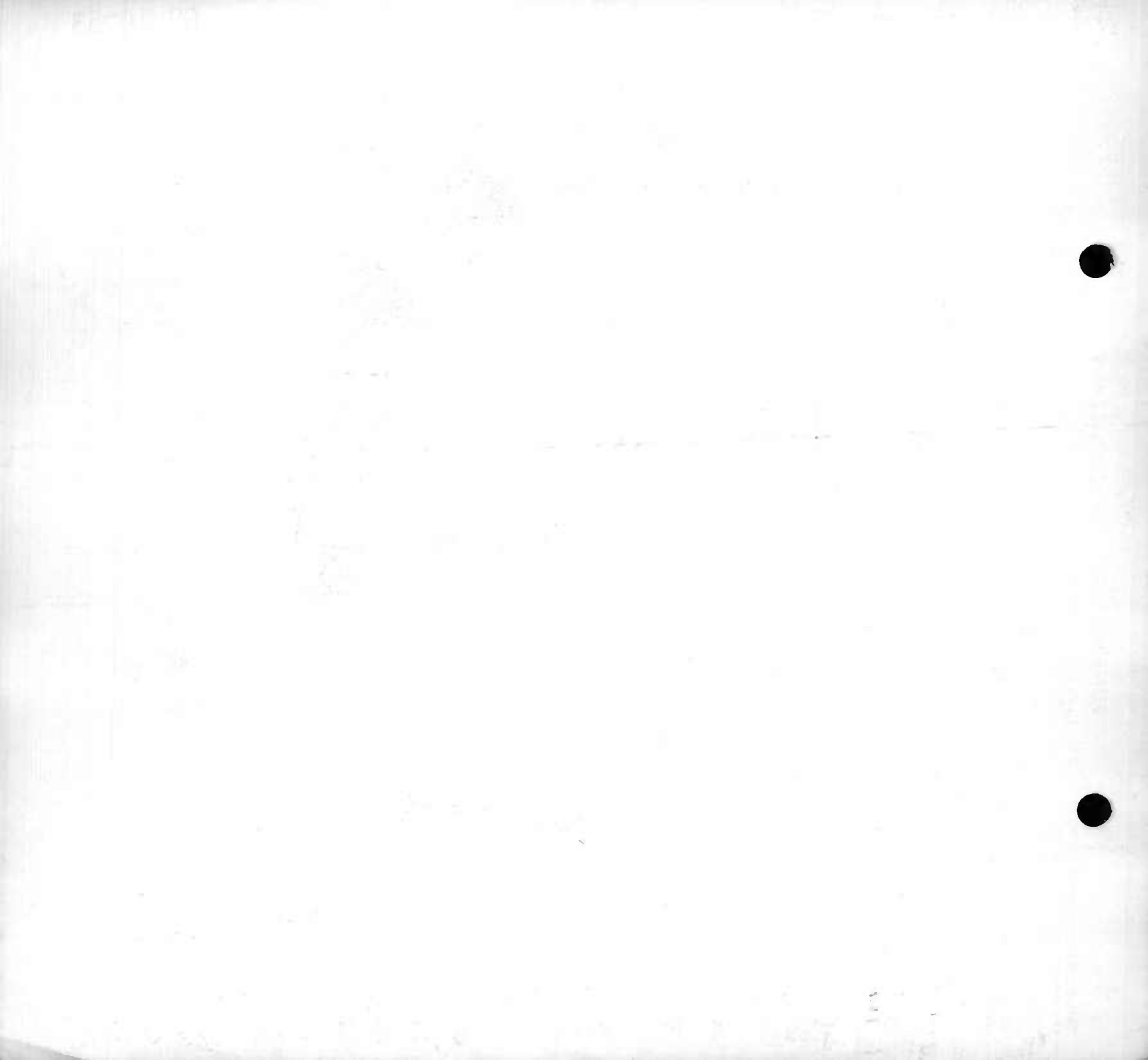
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

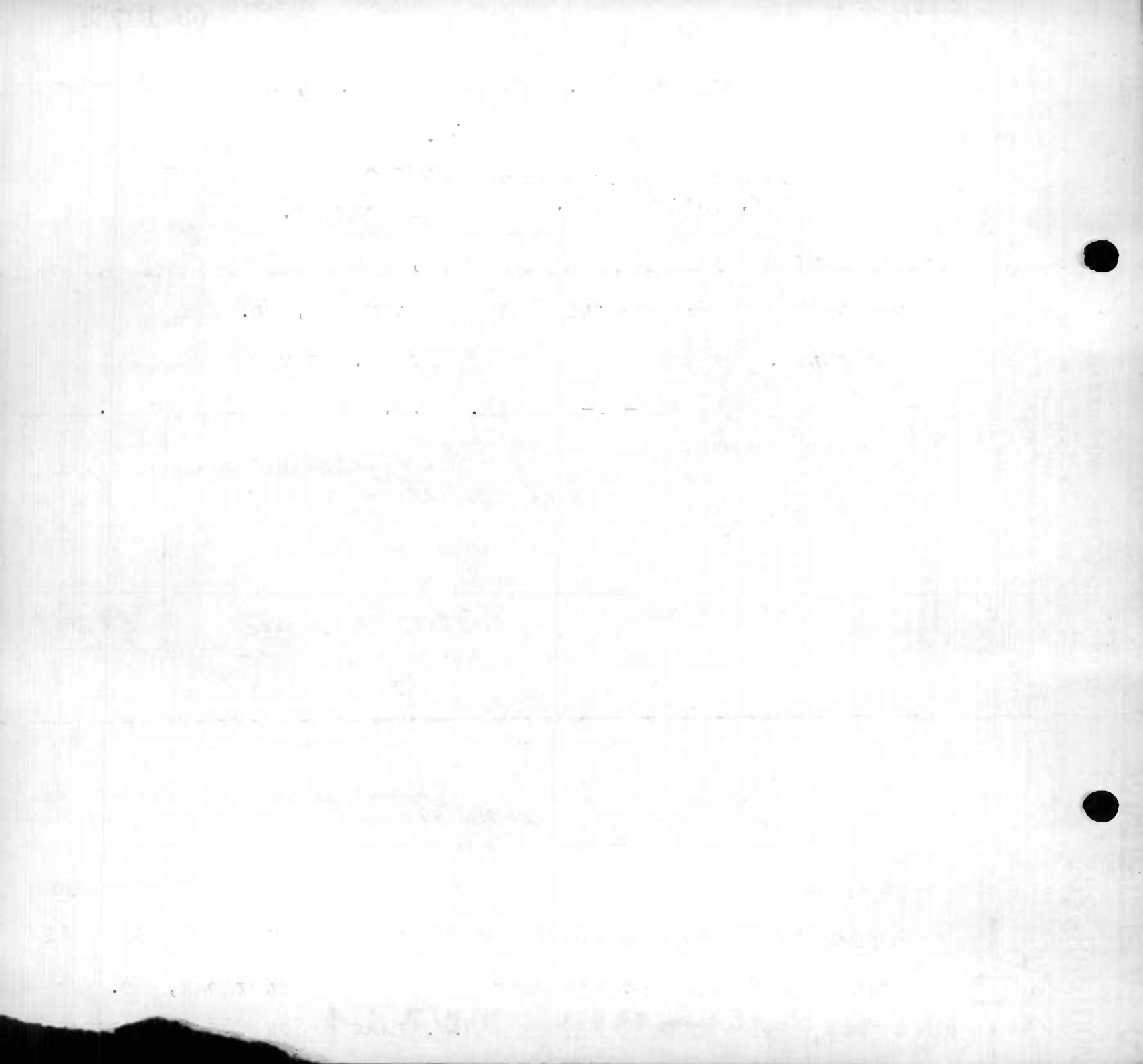
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|--|---|---|--|--|---|
| <div style="display: flex; justify-content: space-between;"> <span style="font-size: 2em;">S-365</span> <span>69 10758</span> </div>   |   | BALTIMORE CITY HEALTH DEPARTMENT<br><b>CERTIFICATE OF DEATH</b>   |  | REG. NO. <span style="font-size: 2em;">69 10758</span>   |   |
| BIRTH NO. <span style="font-size: 2em;">5-365</span>   |   |   | 1. NAME OF DECEASED<br>(Type or Print) <span style="font-size: 1.5em;">MR. Aurelio STRIN</span>  |  |   |
| 2. DATE AND HOUR OF DEATH<br><span style="font-size: 1.5em;">10-30-69</span> <span style="font-size: 1.5em;">10:00</span> A.M.   |   |   |  |  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><span style="font-size: 1.5em;">CHURCH HOME &amp; HOSPITAL</span><br><span style="font-size: 2em;">35</span>  |   |   | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>A. STATE <span style="font-size: 1.5em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.5em;">BALTO. CO.</span><br>C. CITY OR TOWN <span style="font-size: 1.5em;">BALTIMORE</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <span style="font-size: 1.5em;">2341 SEARLES ROAD</span> |  |   |
| 5. SEX <span style="font-size: 1.5em;">M</span>  | 6. RACE <span style="font-size: 1.5em;">W</span>            | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <span style="font-size: 1.5em;">8-9-93</span>   | 9. AGE (In years last birthday) <span style="font-size: 1.5em;">76</span>                          | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><span style="font-size: 1.5em;">Bricklayer</span>   |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><span style="font-size: 1.5em;">Sparrows Point</span>  | 11. BIRTHPLACE (State or foreign country)<br><span style="font-size: 1.5em;">ITALY</span>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><span style="font-size: 1.5em;">ITALY</span>  |
| 13. FATHER'S NAME<br><span style="font-size: 1.5em;">CELESTAN STRIN</span>   |   |   | 14. MOTHER'S MAIDEN NAME<br><span style="font-size: 1.5em;">GIOVILLA BELLGRILLI</span>   |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><span style="font-size: 1.5em;">No</span>  |   | 16. SOCIAL SECURITY NO.<br><span style="font-size: 1.5em;">222-01-2056</span>   | 17. INFORMANT<br><span style="font-size: 1.5em;">FLORA DENTON (DAUGHTER)</span>  |  |   |
| 18. <span style="font-size: 1.5em;">162.1</span> CAUSE OF DEATH  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |   |   |  |  | (A) IMMEDIATE CAUSE <span style="font-size: 1.5em;">CARDIO-RESPIRATORY FAILURE</span><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <span style="font-size: 1.5em;">HEART DISEASE CA. Long</span><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |   |   |  |  |   |
| 19A. DATE OF OPERATION <span style="font-size: 1.5em;">10-30-69</span>   |   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                           |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |   | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.5em;">10-3-69</span> 19 <span style="font-size: 1.5em;">69</span> to <span style="font-size: 1.5em;">10-30</span> 19 <span style="font-size: 1.5em;">69</span><br>that (I) (we) last saw the deceased alive on <span style="font-size: 1.5em;">10-30-69</span> 19 <span style="font-size: 1.5em;">69</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |   |   |  |  |   |
| 23A. SIGNATURE<br><span style="font-size: 1.5em;">Abdus Samad</span> M.D.  |   |   | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>  |  | 23B. DATE SIGNED<br><span style="font-size: 1.5em;">10-30-69</span>   |
| 23C. PHYSICIAN'S NAME (Type)<br><span style="font-size: 1.5em;">ABDUS SAMAD</span> M.D.  |   |   | 23D. ADDRESS<br><span style="font-size: 1.5em;">Church Home &amp; Hospital 100 N Broad way Baltimore Md. 21231</span>  |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><span style="font-size: 1.5em;">Burial</span>  | 24B. DATE<br><span style="font-size: 1.5em;">11/3/69</span> | 24C. NAME OF CEMETERY OR CREMATORY<br><span style="font-size: 1.5em;">Holy Redeemer</span>  |  | 24D. LOCATION (City, town, or county) (State)<br><span style="font-size: 1.5em;">BALTO. MD.</span> |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><span style="font-size: 1.5em;">NOV 3 1969</span>   |   | 25B. NAME OF REGISTRAR<br><span style="font-size: 1.5em;">Robert E. Harker, M.D.</span>   |  | 25C. FUNERAL DIRECTOR<br><span style="font-size: 1.5em;">Joseph N. Zannaris</span>                 |   |
| ADDRESS <span style="font-size: 1.5em;">263 S. Conkling St</span>  |   |   |  |  |   |



FUNERAL DIRECTOR: IMPORTANT

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| BALTIMORE CITY HEALTH DEPARTMENT  |  |   |  | REG. NO. <b>69 10759</b>  |
|---|--|---|--|---|
| <b>BIRTH NO.</b><br><b>1. NAME OF DECEASED</b><br>(Type or Print)   |  | <b>2. DATE AND HOUR OF DEATH</b><br>Oct. 27, 1969 12:40 A. M.   |  |   |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |  | <b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)<br>A. STATE B. COUNTY<br>Md. 2778<br><b>C. CITY OR TOWN</b><br>BALTIMORE<br><b>D. INSIDE CITY LIMITS?</b><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br><b>E. STREET AND NUMBER</b><br>6011 York Rd. |  |   |
| <b>5. SEX</b><br>FEMALE WHITE   |  | <b>6. RACE</b><br>WHITE   |  | <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br>SALES LADY  |  | <b>10B. KIND OF BUSINESS OR INDUSTRY</b><br>HOCHSCHILD KOHN   |  | <b>8. DATE OF BIRTH</b><br>May 21, 1895<br><b>9. AGE</b> (In years last birthday)<br>74   |
| <b>13. FATHER'S NAME</b><br>DANIEL W. KAMMER  |  | <b>14. MOTHER'S MAIDEN NAME</b><br>ANNIE E. LIST  |  |   |
| <b>15. Was Deceased Ever in U. S. Armed Forces?</b><br>(Yes, no or unknown) (If yes, give war or dates of service)  |  | <b>16. SOCIAL SECURITY NO.</b><br>212-03-7104AD   |  | <b>17. INFORMANT</b><br>WM. H. KAMMER   |
| <b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>437.901-250.9<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  | <b>CAUSE OF DEATH</b><br>(A) IMMEDIATE CAUSE<br>Cerebral arteriosclerosis and vascular insufficiency<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C)  |  |   |
| <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b><br>II<br>Diabetic mellitus  |  | <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b><br>2 years<br>5 years   |  |   |
| <b>19A. DATE OF OPERATION</b><br>0  |  | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>   |  | <b>20A. AUTOPSY?</b> (Yes or No)<br>No  |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)  |  | <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)   |
| <b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)<br>(APPROX.)   |  | <b>21E. INJURY OCCURRED</b><br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | <b>21F. HOW DID INJURY OCCUR?</b>   |
| <b>22. I certify that (I) (this hospital) attended the deceased from</b> June 13 1967 <b>to</b> Oct 27 1969 <b>that (I) (we) last saw the deceased alive on</b> Oct 26 1969 <b>and that in (my) (our) opinion death occurred on the date</b> and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                 |  |   |  |   |
| <b>23A. SIGNATURE</b><br>Frederick J. Vollmer M.D.  |  | <b>23B. DATE SIGNED</b><br>Oct. 28, 1969  |  | <b>23C. PHYSICIAN'S NAME</b> (Type)<br>FREDERICK J. VOLLMER M.D.  |
| <b>24A. BURIAL CREMATION, REMOVAL (Specify)</b><br>BURIAL   |  | <b>24B. DATE</b><br>10/29/69  |  | <b>24C. NAME OF CEMETERY OR CREMATORY</b><br>LOUDON PARK  |
| <b>24D. LOCATION</b> (City, town, or county) (State)<br>BALTIMORE, Md.  |  | <b>25A. DATE REC'D BY HEALTH DEPT.</b><br>NOV 3 1969  |  |   |
| <b>25B. NAME OF REGISTRAR</b><br>H.W. MEARS & SON   |  | <b>25C. FUNERAL DIRECTOR</b><br>ADDRESS<br>805 N. VERT  |  |   |

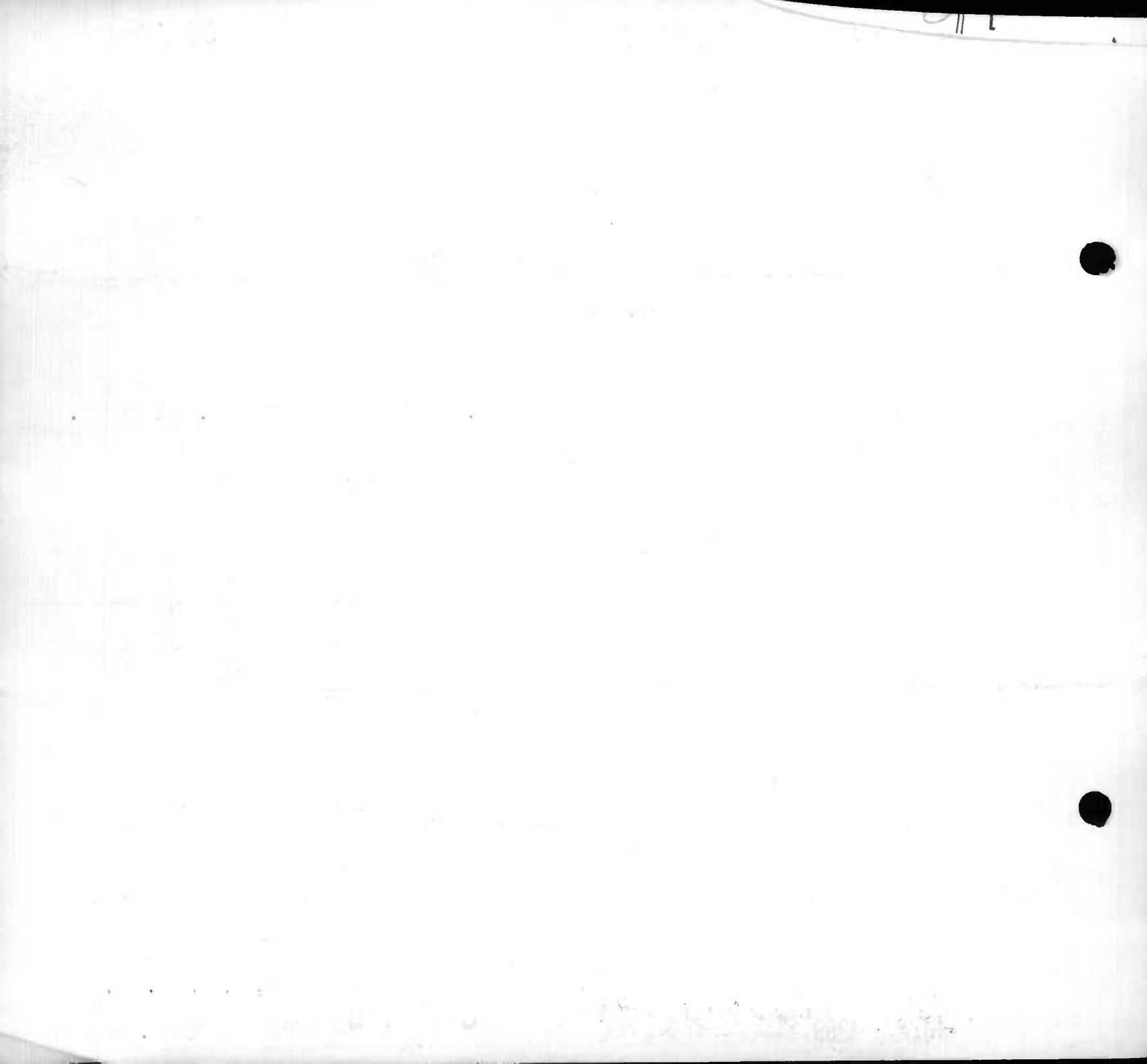




# FUNERAL DIRECTOR: IMPORTANT

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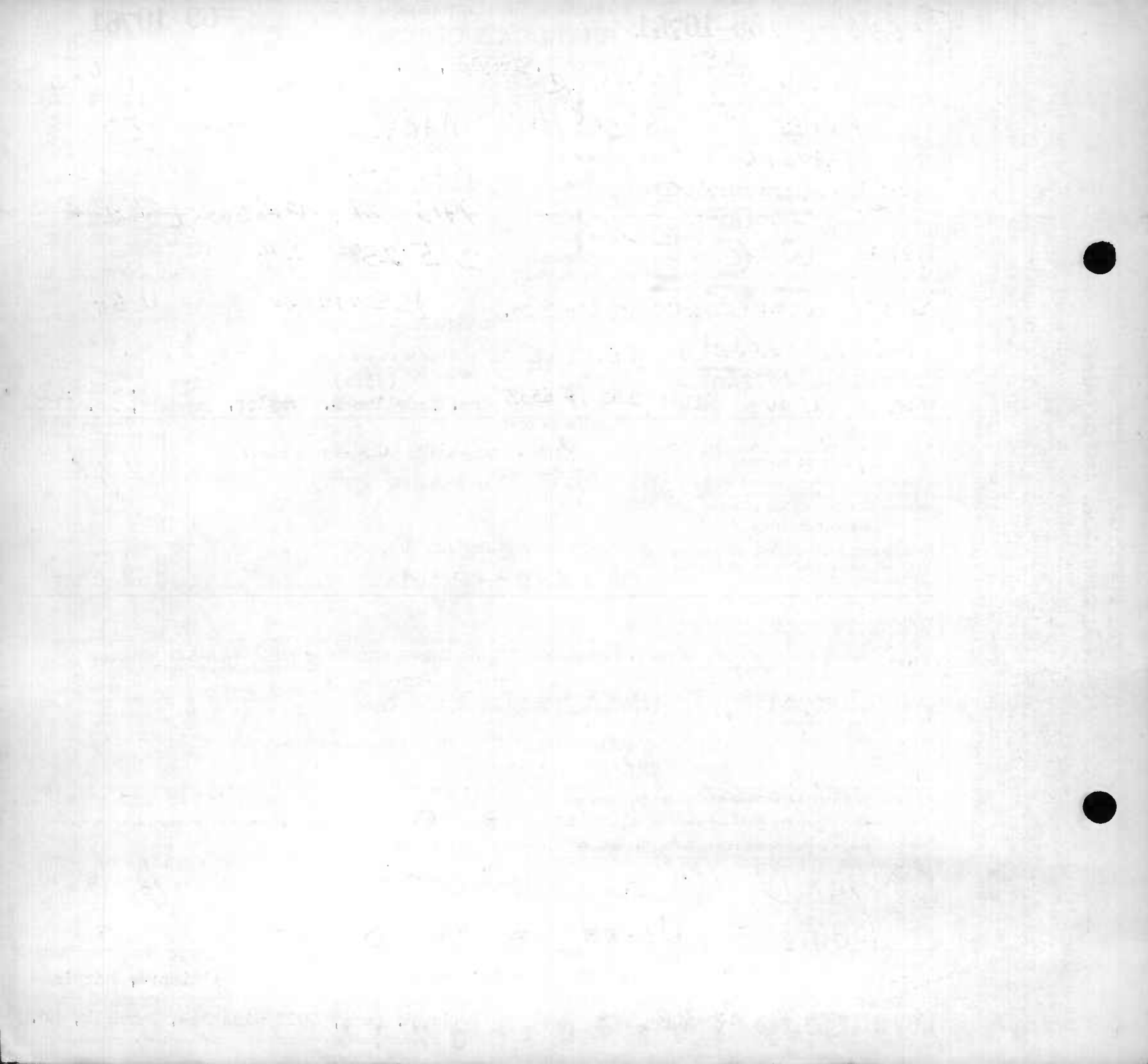
| BALTIMORE CITY HEALTH DEPARTMENT  |           |  |                  | REG. NO. <b>69 10760</b>   |                              |
|---|-----------|--|------------------|--|------------------------------|
| C-624   |           | 69 10760   |                  | CERTIFICATE OF DEATH   |                              |
| BIRTH NO.   |           | 1. NAME OF DECEASED<br>(Type or Print)   |                  | 2. DATE AND HOUR OF DEATH  |                              |
|   |           | Ortilie May Cressler   |                  | 11-1-69 1:55 A.M.  |                              |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |           | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)    |                  | A. STATE B. COUNTY   |                              |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |           | Maryland   |                  | 2404   |                              |
| South Baltimore General Hospital  |           | C. CITY OR TOWN  |                  | D. INSIDE CITY LIMITS?   |                              |
|   |           | Baltimore  |                  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |                              |
|   |           | E. STREET AND NUMBER   |                  |  |                              |
|   |           | 505 E Randall St. 21250  |                  |  |                              |
| 5. SEX  | 6. RACE   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>               | 8. DATE OF BIRTH | 9. AGE (In years last birthday)  | 10. CITIZEN OF WHAT COUNTRY? |
| Female  | Caucasian | WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>            | 3-25-10          | 59   | U.S.                         |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |           | 10B. KIND OF BUSINESS OR INDUSTRY  |                  | 11. BIRTHPLACE (State or foreign country)                                |                              |
| housewife   |           | At. Home   |                  | Maryland   |                              |
| 13. FATHER'S NAME   |           | 14. MOTHER'S MAIDEN NAME   |                  | 12. CITIZEN OF WHAT COUNTRY?   |                              |
| Thomas Simmons  |           | Elsie Horsman  |                  | U.S.   |                              |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |           | 16. SOCIAL SECURITY NO.  |                  | 17. INFORMANT ADDRESS  |                              |
| No  |           |  |                  | Mr. Marvin Simmons 207 S. Fulton Ave.                                    |                              |
| 18. <b>410.9 I</b>  |           | CAUSE OF DEATH   |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |                              |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |           | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                      |                  |  |                              |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)   |           | Myocardial Infarction  |                  |  |                              |
| ANTECEDENT CAUSES   |           | (B) DUE TO, OR AS A CONSEQUENCE OF:  |                  |  |                              |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |           | (C) _____  |                  |  |                              |
| II  |           |  |                  |  |                              |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |           |  |                  |  |                              |
| 19A. DATE OF OPERATION  |           | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                  | 20A. AUTOPSY? (Yes or No)  |                              |
| 2   |           |  |                  | Yes  |                              |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |           | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                              |
|   |           |  |                  |  |                              |
| 21D. TIME OF INJURY (APPROX.)   |           | 21E. INJURY OCCURRED   |                  | 21F. HOW DID INJURY OCCUR?   |                              |
|   |           | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |                  |  |                              |
| 22. I certify that (I) (this hospital) attended the deceased from 10-30 1969 to 11-1 1969 that (I) (we) last saw the deceased alive on 11-1 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |           |  |                  |  |                              |
| 23A. SIGNATURE  |           |  |                  | 23B. DATE SIGNED   |                              |
| Eleanor L. Noon M.D.  |           |  |                  | 11-1-69  |                              |
| 23C. PHYSICIAN'S NAME (Type)  |           | 23D. ADDRESS   |                  |  |                              |
| Eleanor L. Noon M.D.  |           | South Baltimore General Hospital   |                  |  |                              |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |           | 24B. DATE  |                  | 24C. NAME OF CEMETERY or CREMATORY                                       |                              |
| Burial  |           | 11 4 69  |                  | Glen Haven   |                              |
|   |           | 24D. LOCATION  |                  | (City, town, or county) (State)  |                              |
|   |           | Glen Burnie, A. A. Co. Md.   |                  |  |                              |
| 25A. DATE REC'D BY HEALTH DEPT.   |           | 25B. NAME OF REGISTRAR   |                  | 25C. FUNERAL DIRECTOR ADDRESS  |                              |
| NOV 3 1969  |           | Robert E. Faber, M.D.  |                  | Mc Cully 130 E. Fort Ave   |                              |



**FUNERAL DIRECTOR: IMPORTANT**

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|  |  |  |  |   |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|
| T-646  |  | 69 10761   |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | X  |  | REG. NO. 69 10761  |  |
| BIRTH NO.  |  | 1. NAME OF DECEASED<br>(Type or Print) <b>VERNON L. TRAYLOR</b>  |  | 2. DATE AND HOUR OF DEATH<br><b>10/30/69</b>  |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><b>36 Franklin Square Hospital</b> |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b> <b>5300</b> |  |
| 5. SEX <b>Male</b>   |  | 6. RACE <b>White</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>2/5/25</b>  |  | 9. AGE (In years last birthday) <b>44</b>  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>STEEL WORKER</b>   |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Bethlehem Steel Co.</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>KENTUCKY</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  |
| 13. FATHER'S NAME<br><b>FRANK VERNON TRAYLOR</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>LOUELLA LITTLE</b>   |  |  |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes</b>   |  | 16. SOCIAL SECURITY NO.<br><b>210 14 655</b>   |  | 17. INFORMANT (Wife)<br><b>Mrs. Madeline E. Traylor</b>   |  | ADDRESS<br><b>7913 St. Bridget La. Dundalk, Md. 21222</b>                                    |  |  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><b>BRONCHOGENIC CARCINOMA</b>  |  | 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>1 yr</b>  |  | (B) DUE TO, OR AS A CONSEQUENCE OF:  |  | (C) <b>PNEUMONIA</b><br><b>2 mon</b>   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |  |  |   |  |  |  |  |  |
| 19A. DATE OF OPERATION<br><b>2</b>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)<br><b>Yes</b>   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |  |  |  |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                          |  | 21F. HOW DID INJURY OCCUR?  |  |  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>May 1969</b> to <b>Oct 30 1969</b> , that (I) (we) lost saw the deceased alive on <b>Oct 28 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |
| 23A. SIGNATURE<br><b>Louis O. Olsen</b>  |  |  |  | 23B. DATE SIGNED<br><b>10/30/69</b>   |  |  |  |  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Louis O. Olsen</b>  |  | 23D. ADDRESS<br><b>914 D ST. - 21219</b>   |  |   |  |  |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>11/3/69</b>  |  | 24C. NAME of CEMETERY or CREMATORY<br><b>Holly Hill Memorial Gardens</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>                  |  |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 3 1969</b>   |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor</b>  |  | 25C. FUNERAL DIRECTOR<br><b>John J. Duda</b>  |  | ADDRESS<br><b>7922 Wise Ave. Dundalk, Md.</b>  |  |  |  |



## FUNERAL DIRECTOR: IMPORTANT

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Q-300 69 10762 BALTIMORE CITY HEALTH DEPARTMENT REG. NO. 69 10762

**CERTIFICATE OF DEATH**

BIRTH NO. 1. NAME OF DECEASED (Type or Print) **QUADE, WALTER** 2. DATE AND HOUR OF DEATH **10/30/69 7:50 A.M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE **Maryland** B. COUNTY **2636**

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) **Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224** C. CITY OR TOWN **Baltimore** D. INSIDE CITY LIMITS? YES ☒ NO ☐

5. SEX **Male** 6. RACE **White** 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH **2/5/23** 9. AGE (In years last birthday) **46** If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Repairman - Chevrolet Co.** 11. BIRTHPLACE (State or foreign country) **Minnesota** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Henry Quade** 14. MOTHER'S MAIDEN NAME **Martha Senne**

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) **Yes WWII** 16. SOCIAL SECURITY NO. **218-26-6179** 17. INFORMANT ADDRESS **Records: BCH-4940 Eastern Avenue 21224**

18. **410.91** CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) **Myocardial infarction**

ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION **2** 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED **YES** 20A. AUTOPSY? (Yes or No) **YES** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? **YES**

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐ 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from **10/30/69** 19 to **10/30/69** 19, that (I) (we) last saw the deceased alive on **10/30/69** 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE **J.R. Wands mb** 23B. DATE SIGNED **10/30/69** 23C. PHYSICIAN'S NAME (Type) **J.R. Wands** 23D. ADDRESS **Baltimore City Hospitals 4940 Eastern Ave., Baltimore, Md. 21224**

24A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **11/3/69** 24C. NAME OF CEMETERY OR CREMATORY **Meadowridge Memorial Park** 24D. LOCATION (City, town, or county) (State) **Dorsey, Maryland**

25A. DATE REC'D BY HEALTH DEPT. **NOV 3 1969** 25B. NAME OF REGISTRAR **John P. Duda** 25C. FUNERAL DIRECTOR ADDRESS **7922 Wise Ave. Dundalk, Md.**

WALTER

222

W-256

69 10763

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 10763

BIRTH NO.

|   |  |   |  |
|---|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>A. GEORGE WISNER</b>  |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> M.   |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>31 CITY HOSPITAL</b>   |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>October 29, 1969 2:25 A.M.</b>   |  |
| 6. SEX<br><b>Male</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 7. RACE<br><b>White</b>   |  | C. CITY OR TOWN<br><b>Dundalk</b>   |  |
| 9. DATE OF BIRTH<br><b>May 30, 1944</b>   |  | 10. AGE (In years last birthday)<br><b>25</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Truck Driver - Crown</b>  |  | 14B. KIND OF BUSINESS OR INDUSTRY<br><b>Cork &amp; Seal</b>   |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes Vietnam</b>   |  | 17. SOCIAL SECURITY NO.<br><b>212-42-3673</b>   |  |
| 15. MOTHER'S MAIDEN NAME<br><b>Gladys Hembree</b>   |  | 18. INFORMANT (Father) <b>535 Larkfield Rd.</b><br><b>Mr. Elmer F. Wisner, Dundalk, Md. 21224</b>   |  |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>E 8 / 2 / 2</b><br><b>Multiple Traumatic Injuries</b>  |  | CAUSE OF DEATH<br><b>Multiple Traumatic Injuries</b>  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |  | (B) DUE TO, OR AS A CONSEQUENCE OF:   |  |
|   |  | (C) DUE TO, OR AS A CONSEQUENCE OF:   |  |
| 20A. DATE OF OPERATION<br><b>2</b>  |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Street</b>   |  |
| 22D. TIME OF INJURY (APPROX.)<br><b>Oct. 29, 1969 1:20 A.M.</b>   |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>Intersection, O'Donnell and Oldham Streets</b>   |  | 22F. HOW DID INJURY OCCUR?<br><b>Driver of motorcycle collided with tractor trailer truck</b>   |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D.<br>EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b><br>DATE SIGNED <b>10/29/69</b> |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 24B. DATE<br><b>11/1/69</b>   |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Oak Lawn Cemetery</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 3 1969</b>  |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Jackson, M.D.</b>  |  |
| 25C. FUNERAL DIRECTOR<br><b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>   |  | ADDRESS   |  |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |   |   |  | REG. NO. <b>69 10764</b>                  |
|---|---|---|--|---|
| G-412   |   | 69 10764 CERTIFICATE OF DEATH   |  |   |
| BIRTH NO. _____   |   |   |  |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>ELIZABETH GOLEBIOWSKI</b>   |   |   | 2. DATE AND HOUR OF DEATH<br><b>10/29/69 4 AM</b>  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>JOHNS HOPKINS HOSPITAL</b>  |   |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>101</b>   |   |
| 33 Johns Hopkins Hospital   |   |   | C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |
|   |   |   | E. STREET AND NUMBER<br><b>1106 S. Curley Street</b>   |   |
| 5. SEX<br><b>Female</b>   | 6. RACE<br><b>White</b>                               | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6/27/98</b>   | 9. AGE (In years last birthday) <b>71</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired - Grocery Store Owner</b>   |   | 10B. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (State or foreign country)<br><b>Poland</b>   |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |   |   | 13. FATHER'S NAME<br><b>John Budny</b>   |   |
| 14. MOTHER'S MAIDEN NAME<br><b>?</b>  |   |   | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |   |
| 16. SOCIAL SECURITY NO.<br><b>217-01-1072</b>   |   |   | 17. INFORMANT <b>1106 S. Curley Street</b><br><b>Mr. Ben Kupnicki, Baltimore, Md. 21224</b>  |   |
| 18. <b>412, 314-174X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>PROBABLE METASTATIC BREAST Ca</b> |   |   | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <b>CARDIO RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) <b>ASHD, ANOXIA</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) _____<br><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |
| 19A. DATE OF OPERATION  |   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20A. AUTOPSY? (Yes or No) <b>No</b>  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |   | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>   | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>9/20</b> 19 <b>69</b> to <b>10/29</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>10/29</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.  |   |   |  |   |
| 23A. SIGNATURE<br><b>Ralph DeFrongo</b><br>DEGREE <b>MD</b>   |   |   | 23B. DATE SIGNED<br><b>10/29/69</b>  |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>RALPH DEFRONZO</b><br>DEGREE <b>MD</b>   |   |   | 23D. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL, BALTO.</b><br>MD.   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 24B. DATE<br><b>10/31/69</b>                          | 24C. NAME OF CEMETERY OR CREMATORY<br><b>St. Stanislaus Cemetery</b>  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>  |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 3 1969</b>  | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, MD</b> | 25C. FUNERAL DIRECTOR ADDRESS<br><b>John J. Duda, 2829 Hudson St. Balto., Md.</b>   |  |   |

JOHN HOPKINS HOSPITAL

CARDIO RESPIRATORY ARREST

AND, ANOXIA

PROBABLY METABOLIC ACIDOSIS

NO

10/10

10/10

10/10

10/10

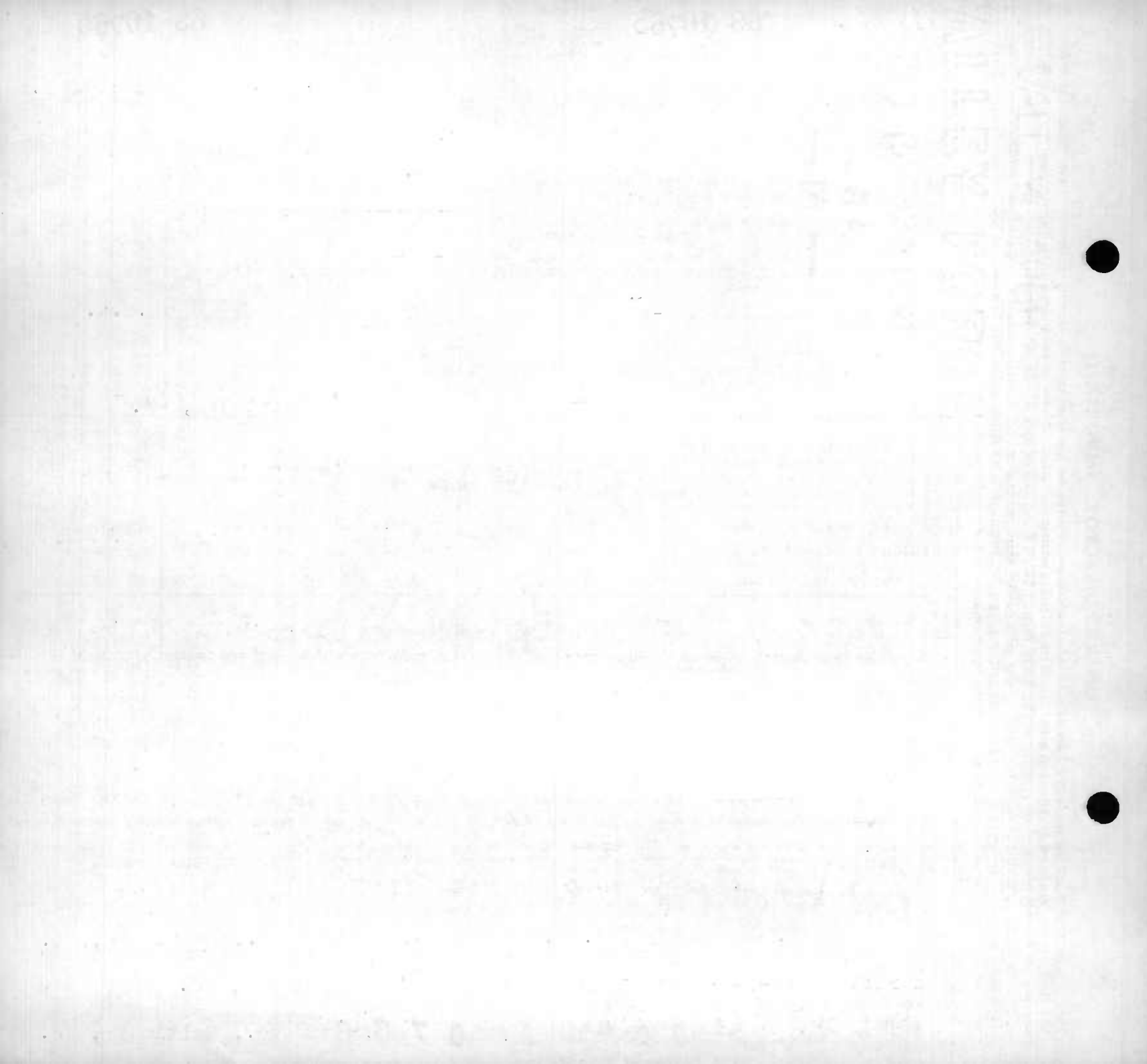
Ralph DeFuria

RALPH DEFURIA

JOHN HOPKINS HOSPITAL

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

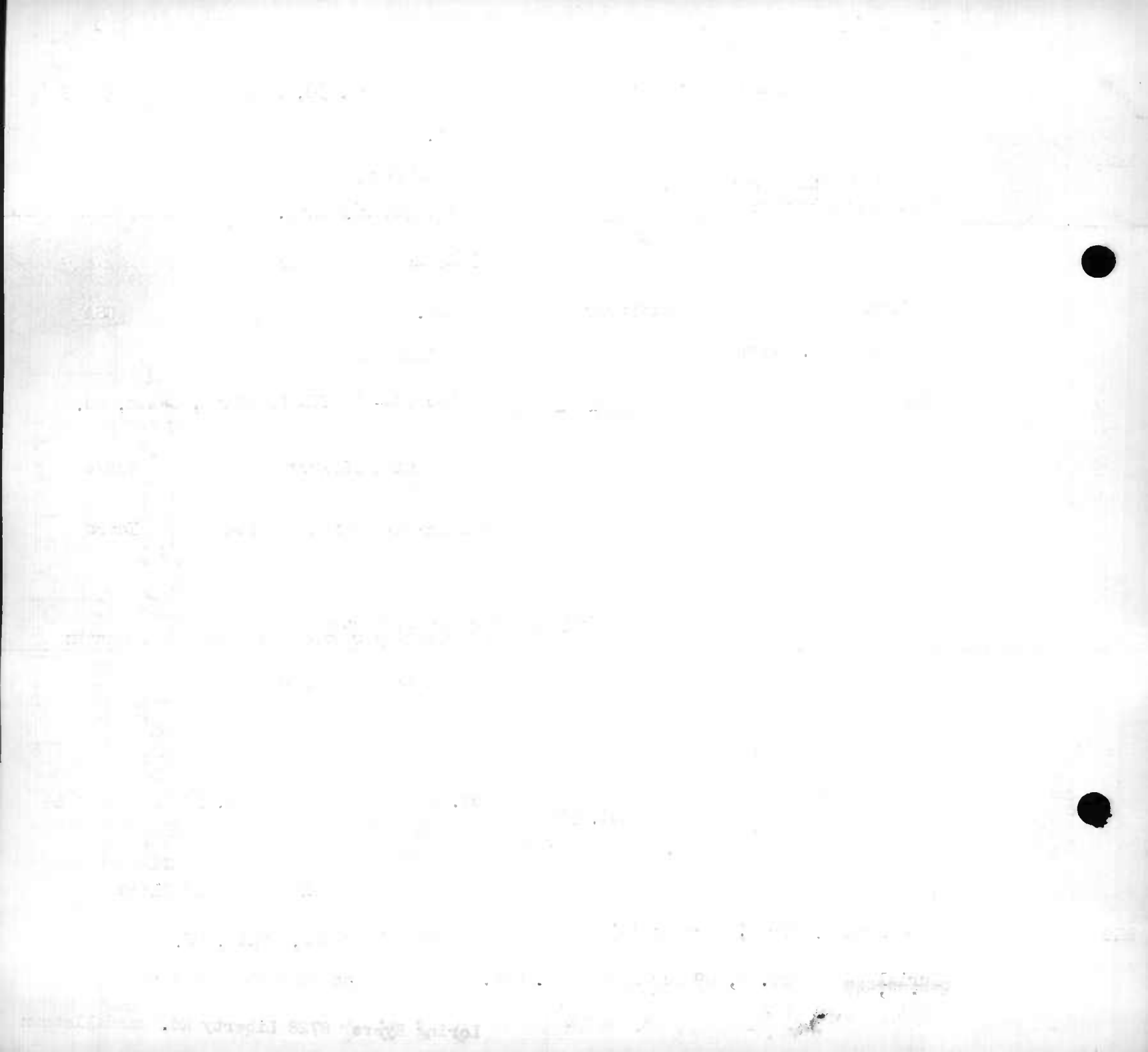
| BALTIMORE CITY HEALTH DEPARTMENT  |  |  |  | REG. NO. <b>69 10765</b>   |  |
|---|--|--|--|--|--|
| <b>1. NAME OF DECEASED</b><br>(Type or Print) <b>DIAMOND MILLER</b>   |  |  |  | <b>2. DATE AND HOUR OF DEATH</b><br><b>October 30, 1969   12:05 P.M.</b>   |  |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><br><b>33 Johns Hopkins Hospital</b>   |  |  |  | <b>4. USUAL RESIDENCE</b> (Where deceased lived, If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>2644</b> |  |
| <b>5. SEX</b> <b>Female</b> <b>6. RACE</b> <b>White</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>   |  |  |  | <b>8. DATE OF BIRTH</b> <b>11-14-20</b> <b>9. AGE</b> (In years last birthday) <b>48</b>   |  |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>   |  |  |  | <b>11. BIRTHPLACE</b> (State or foreign country) <b>Greece</b>   |  |
| <b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>-</b>   |  |  |  | <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>  |  |
| <b>13. FATHER'S NAME</b> <b>George Boules</b>   |  |  |  | <b>14. MOTHER'S MAIDEN NAME</b> <b>Argiro Lazos</b>  |  |
| <b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>   |  |  |  | <b>16. SOCIAL SECURITY NO.</b> <b>-</b>  |  |
| <b>17. INFORMANT</b> <b>Steve Miller</b>  |  |  |  | <b>ADDRESS</b> <b>6006 Moravia Park Drive Baltimore, Md.</b>   |  |
| <b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.)<br><br><b>CAUSE OF DEATH</b><br>(A) IMMEDIATE CAUSE <b>Cardiac failure</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) <b>Rheumatic heart disease.</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) <b>-</b> |  |  |  | <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b><br><br><b>Immediate</b><br><br><b>35 yrs.</b>  |  |
| <b>II</b><br><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b> <b>Metastatic carcinoma of breast.</b>   |  |  |  | <b>9 yrs.</b>  |  |
| <b>19A. DATE OF OPERATION</b> <b>10/27/69</b>   |  | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>lv</b>  |  | <b>20A. AUTOPSY?</b> (Yes or No) <b>lv</b>   |  |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>   |  | <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)  |  |
| <b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)  |  | <b>21E. INJURY OCCURRED</b><br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | <b>21F. HOW DID INJURY OCCUR?</b>  |  |
| <b>22. I certify that (I) (this hospital) attended the deceased from 5/27 1958 to 10/30 1969, that (I) (we) last saw the deceased alive on 2/10 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</b>   |  |  |  |  |  |
| <b>23A. SIGNATURE</b><br><i>George W. Murgatroyd Jr. M.D.</i>   |  |  |  | <b>23B. DATE SIGNED</b> <b>10/31/69</b>  |  |
| <b>23C. PHYSICIAN'S NAME (Type)</b> <b>George W. Murgatroyd, M. D.</b>  |  |  |  | <b>23D. ADDRESS</b> <b>1201 N. Calvert St., Baltimore, Md.</b>   |  |
| <b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b>   |  | <b>24B. DATE</b> <b>11-1-69</b>  |  | <b>24C. NAME OF CEMETERY or CREMATORY</b> <b>Oak Lawn Cemetery</b>   |  |
| <b>24D. LOCATION</b> <b>Baltimore, Md.</b>  |  | <b>24E. FUNERAL DIRECTOR</b> <b>Nicholas T. Matthews</b>   |  |  |  |
| <b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>NOV 3 1969</b>  |  | <b>25B. NAME OF REGISTRAR</b> <b>Robert E. Fisher, M.D.</b>  |  | <b>25C. ADDRESS</b> <b>8027 Eastern Ave., Baltimore, Md.</b>   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|--|------------|--|--|--|--|--|
| E-250  |  | 69 10766   |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | 69 10766   |  |
| BIRTH NO.  |  |            |  | CERTIFICATE OF DEATH   |  |  |  |
| 1. NAME OF DECEASED<br>(Type or Print)   |  |            |  | 2. DATE AND HOUR OF DEATH  |  |  |  |
| Elisha King Esham  |  |            |  | Oct. 30, 1969 9 P M.   |  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |            |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)    |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |  |            |  | A. STATE B. COUNTY   |  |  |  |
| US Public Health Service Hospital<br>3100 Wyman Parkway  |  |            |  | Pa. V-35   |  |  |  |
| 5. SEX 6. RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |            |  | 8. DATE OF BIRTH   |  | 9. AGE (In years last birthday)  |  |
| M W  |  |            |  | 3/19/16  |  | 53   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |            |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)                                |  |
| Mate   |  |            |  | Seafarer   |  | Md.  |  |
| 13. FATHER'S NAME  |  |            |  | 14. MOTHER'S MAIDEN NAME   |  |  |  |
| King W. Esham  |  |            |  | Anna Hudson  |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |  |            |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |  |
| No   |  |            |  | 194-18-5675  |  | Records- US PHS Hospital, Balto, Md.                                     |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH   |  |            |  | CAUSE OF DEATH   |  |  |  |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  |  |            |  | (A) IMMEDIATE CAUSE  |  |  |  |
| ANTECEDENT CAUSES  |  |            |  | Renal failure  |  |  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  |            |  | DUE TO, OR AS A CONSEQUENCE OF:  |  |  |  |
|  |  |            |  | Multicystic renal disease  |  |  |  |
|  |  |            |  | DUE TO, OR AS A CONSEQUENCE OF:  |  |  |  |
|  |  |            |  | (C) _____  |  |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |            |  | Biliary obstruction secondary to metastatic carcinoma of colon                           |  |  |  |
| 19A. DATE OF OPERATION   |  |            |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)  |  |
|  |  |            |  |  |  | yes  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  |            |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
|  |  |            |  |  |  |  |  |
| 21D. TIME OF INJURY (APPROX.)  |  |            |  | 21E. INJURY OCCURRED   |  | 21F. HOW DID INJURY OCCUR?   |  |
|  |  |            |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |  |  |  |
| 22. I certify that (1) (this hospital) attended the deceased from Oct. 1 1969 to Oct. 30 19 69 that (1) (we) lost saw the deceased alive on Oct. 30 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. |  |            |  |  |  |  |  |
| 23A. SIGNATURE   |  |            |  |  |  | 23B. DATE SIGNED   |  |
| Samuel P. Ward, M.D.   |  |            |  |  |  | 10/31/69   |  |
| 23C. PHYSICIAN'S NAME (Type)   |  |            |  |  |  | 23D. ADDRESS   |  |
| Samuel P. Ward, Surgeon (R)  |  |            |  |  |  | US PHS Hospital, Balto, Md.  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |  | 24B. DATE  |  | 24C. NAME OF CEMETERY OR CREMATORY   |  | 24D. LOCATION (City, town, or county) (State)                            |  |
| Burial   |  | Nov. 2, 69 |  | Ocracoke Comm. Cem.  |  | Ocracoke North Carolina  |  |
| 25A. DATE RECEIVED BY REGISTRAR  |  |            |  | 25C. FUNERAL DIRECTOR ADDRESS  |  |  |  |
| Nov 3 1969   |  |            |  | Loring Byers 8728 Liberty Rd. Randallstown   |  |  |  |



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L-300 69 10767 BALTIMORE CITY HEALTH DEPARTMENT

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 10767

BIRTH NO.

|   |   |  |  |
|---|---|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) CONDON LETT  |   | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> October 29, 1969 8:38 P.M.  |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>33 Johns Hopkins Hospital  |   | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br>October 29, 1969 8:38 P.M.   |  |
| 6. SEX Male   |   | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland B. COUNTY 909   |  |
| 7. RACE Negro   | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | C. CITY OR TOWN D. INSIDE CITY LIMITS?<br>Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 9. DATE OF BIRTH<br>APR 1 1913  | 10. AGE (In years last birthday) 56<br>If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.   | E. STREET AND NUMBER<br>1309 Wilcox Street   |  |
| 11. BIRTHPLACE (State or foreign country)<br>MONROE ALABAMA   | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 13. FATHER'S NAME<br>Hibbert LETT  |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>LABORER  | 14B. KIND OF BUSINESS OR INDUSTRY<br>INDUSTRY   | 15. MOTHER'S MAIDEN NAME<br>VIRNER JOHNSON   |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO   | 17. SOCIAL SECURITY NO.<br>508-16-0984  | 18. INFORMANT ADDRESS<br>MARY CURTIS 904 N. EDEN ST.   |  |
| 19. CAUSE OF DEATH<br>E965X<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |   | (A) IMMEDIATE CAUSE<br>Gunshot wound of back<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:  |  |
| 20A. DATE OF OPERATION<br>2   |   | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |   | 22B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)<br>street   |  |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>Madison Avenue & Ashland 1002   |   | 22F. HOW DID INJURY OCCUR?<br>Shot by unknown assailant  |  |
| 22D. TIME OF INJURY (APPROX.) 10-29-69 7:15 P.M.  |   | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>   |   |  |  |
| ACTUAL SIGNATURE<br>Charles S. Springate, M.D.  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED<br>October 30, 1969 |  |
| 24A. BURIAL-CREMATATION, REMOVAL (Specify)<br>REMOVAL   | 24B. DATE<br>Nov. 2, 1969   | 24C. NAME OF CEMETERY or CREMATORY<br>New Hope A.M.E. Zion Cem   | 24D. LOCATION (City, town, or county) (State)<br>Burrhead Corn ALABAMA |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 3 1969   | 25B. NAME OF REGISTRAR<br>Robert E. Taylor, M.D.  | 25C. FUNERAL DIRECTOR<br>CALVIN B. SCRUGGS   | ADDRESS<br>1412 E. Preston Street                                      |

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1  
F-655 69 10768 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 69 10768

BIRTH NO.

|  |  |  |  |
|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>LEO FREEMAN</b>   |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> M.                                 |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>00 1547 Myrtle Avenue</b> |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>October 28, 1969 12:45 P.M.</b>   |  |
| 6. SEX<br><b>Male</b>  |  | 7. RACE<br><b>Negro</b>  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>1402</b> |  |
| 9. DATE OF BIRTH<br>10. AGE (In years last birthday) <b>60</b><br>If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.   |  | C. CITY OR TOWN<br><b>Baltimore</b><br>D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | E. STREET AND NUMBER<br><b>1547 Myrtle Avenue</b>  |  |
| 12. CITIZEN OF<br><b>U S A</b>   |  | 13. FATHER'S NAME<br><b>William</b>  |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>  |  | 14B. KIND OF BUSINESS OR INDUSTRY  |  |
| 15. MOTHER'S MAIDEN NAME<br><b>Mary</b>  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no or unknown) (If yes, give war or dates of service)                                 |  |
| 17. SOCIAL SECURITY NO.  |  | 18. INFORMANT<br><b>Mrs Anna Freeman, 716 Myrtle Ave</b><br>ADDRESS  |  |

|  |  |  |  |
|--|--|--|--|
| 19. <b>41241</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Arteriosclerotic Cardiovascular Disease</b><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF: |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |  |  |  |

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 20A. DATE OF OPERATION   |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 21. AUTOPSY? (Yes or No)<br><b>no</b>                                    |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |  |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 22F. HOW DID INJURY OCCUR?   |  |

23. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: **Natural causes** ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: *Ronald N. Kornblum* M.D.  
EXAMINER'S NAME (Type) **Ronald N. Kornblum, M.D.**

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED **10/29/69**

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b> |  | 24B. DATE<br><b>11/5/69</b>                            |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Mt Auburn Cemetery</b> |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore M</b> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 3 1969</b>      |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Jaber, M.D.</b> |  | 25C. FUNERAL DIRECTOR<br><b>Adolphus Halstead</b>               |  | ADDRESS<br><b>1206 W north AV</b>                                   |  |

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

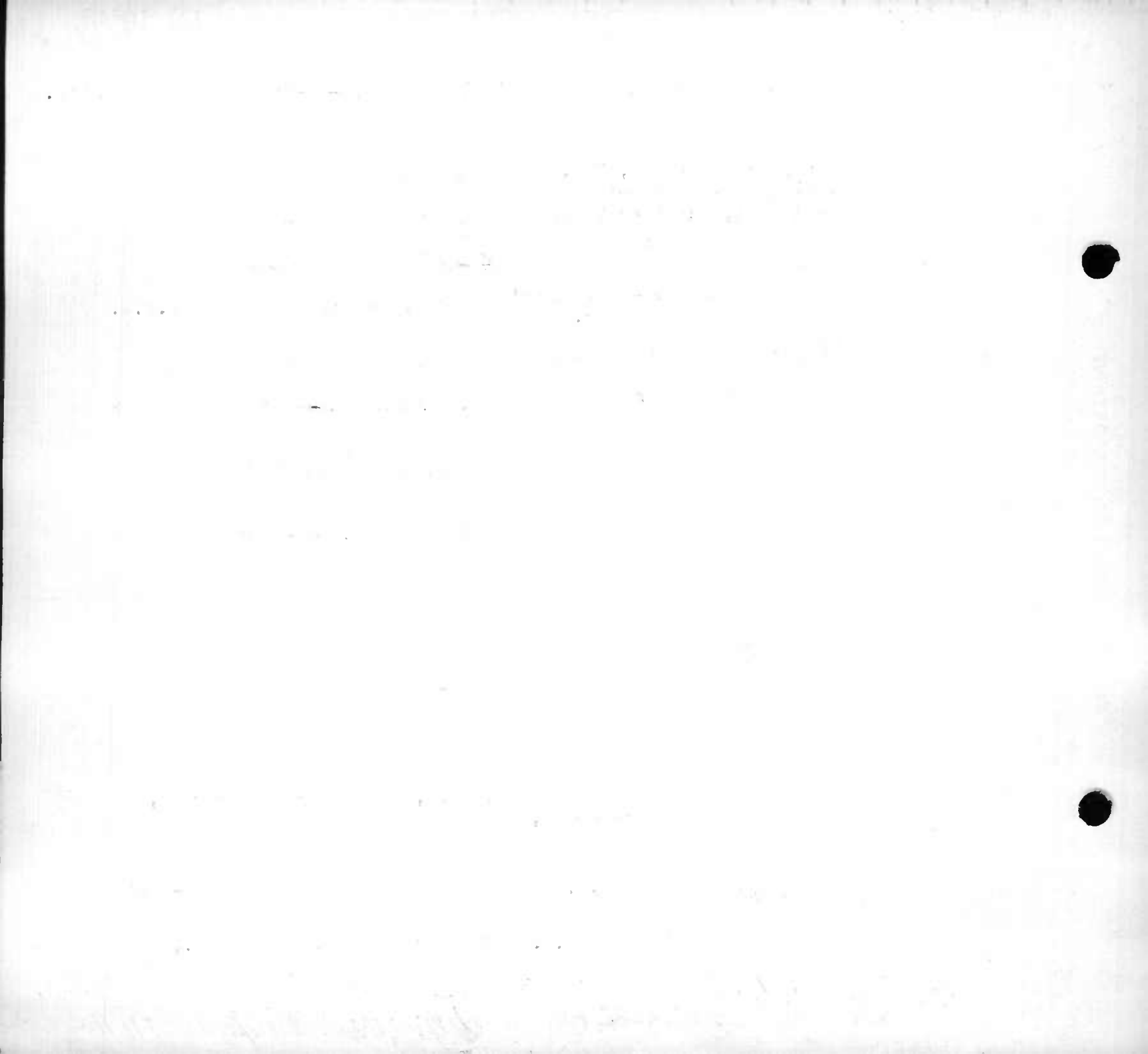
| BALTIMORE CITY HEALTH DEPARTMENT  |                         |   |   | REG. NO. <b>69 10769</b>   |  |
|---|-------------------------|---|---|--|--|
| BIRTH NO. <b>S-353</b>  |                         | 69 10769  |   | <b>CERTIFICATE OF DEATH</b>  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>STANTON, Charles Edward</b>   |                         |   | 2. DATE AND HOUR OF DEATH<br><b>10-30-69 8:30 P.M.</b>  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                         |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)   |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>23 Veterans Administration Hospital</b><br><b>3900 Loch Raven Boulevard</b><br><b>Baltimore, Maryland 21218</b>  |                         |   | A. STATE <b>Maryland</b><br>B. COUNTY <b>1703</b>   |  |  |
|   |                         |   | C. CITY OR TOWN<br><b>Baltimore</b>   |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
|   |                         |   | E. STREET AND NUMBER<br><b>1137 Arggle Avenue</b>   |  |  |
| 5. SEX<br><b>Male</b>   | 6. RACE<br><b>Negro</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>8-26-23</b>  | 9. AGE (in years last birthday)<br><b>46</b>                             | 10. Under 1 Yr. Months: Days: Hours: Min.  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Construction</b>  |                         |   | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                    |
| 13. FATHER'S NAME<br><b>Sylvester Stanton</b>   |                         |   | 14. MOTHER'S MAIDEN NAME<br><b>Ella Machlin</b>   |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes 3-9-43 to 1-4-46</b>   |                         |   | 16. SOCIAL SECURITY NO.<br><b>217-18-54-99</b>  |  | 17. INFORMANT <b>VA Hospital Records</b><br><b>Baltimore, Maryland 21218</b>       |
| 18. <b>582X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Chronic Glomerulonephritis with Arteriosclerotic Cardiovascular Disease. Acute Lacerations of Gastric Wall.</b>   |                         |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                         |   | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF: |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                         |   |   |  |  |
| 19A. DATE OF OPERATION<br><b>2</b>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)<br><b>Yes</b>                                  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |   | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 27, 1969</b> to <b>October 30, 1969</b> that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>October 30, 1969</b> and that <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death. |                         |   |   |  |  |
| 23A. SIGNATURE<br><b>M. J. Shafi</b>  |                         |   | 23B. DATE SIGNED<br><b>Nov 1, 1969</b>  |  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>M. JAVAID SHAFI MD</b>   |                         |   | 23D. ADDRESS<br><b>Veterans Administration Hosp., Balto., Md.</b>   |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                         | 24B. DATE<br><b>11/5/69</b>   |   | 24C. NAME OF CEMETERY or CREMATORY<br><b>National Cemetery</b>           |  |
| 24D. LOCATION<br><b>Baltimore Md</b>  |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 3 1969</b>  |   |  |  |
| 25B. NAME OF REGISTRAR<br><b>Robert E. Barber</b>   |                         | 25C. FUNERAL DIRECTOR<br><b>Adolphus Halstead</b>   |   |  |  |
| 25D. ADDRESS<br><b>1206 W North Ave</b>   |                         |   |   |  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO.   |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO.  |  |
|---|--|---|--|---|--|
| 69 10770  |  | 69 10770  |  | 69 10770  |  |
| 1. NAME OF DECEASED<br>(Type or Print)  |  | 2. DATE AND HOUR OF DEATH   |  |   |  |
| Charles Glen Ham (Hamm)   |  | 10-29-69 10:30 a.m.   |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)   |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |  | A. STATE B. COUNTY  |  |   |  |
| 39 Provident Hospital, Inc.<br>1514 Division Street<br>Baltimore, Maryland 21217  |  | Maryland<br>C. CITY OR TOWN D. INSIDE CITY LIMITS?<br>Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 5. SEX  |  | 6. RACE   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  |
| Male  |  | Negro   |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 8. DATE OF BIRTH  |  |
|   |  | Retired- Brickfords Inc.  |  | 5-5-07 62   |  |
| 13. FATHER'S NAME   |  | 14. MOTHER'S MAIDEN NAME  |  | 9. AGE (in years last birthday)   |  |
| Charles Hamm  |  | Anna Cudde  |  | 11. BIRTHPLACE (State or foreign country)   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO.   |  | 12. CITIZEN OF WHAT COUNTRY?  |  |
|   |  |   |  | U.S.A.  |  |
| 17. INFORMANT   |  | ADDRESS   |  |   |  |
| Mrs. Lucille Ham Wife   |  | SAME  |  |   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |  | CAUSE OF DEATH  |  |   |  |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)   |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:   |  |   |  |
| ANTECEDENT CAUSES   |  | Renal Failure   |  |   |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |  | (B) DUE TO, OR AS A CONSEQUENCE OF:   |  |   |  |
|   |  | Pyelonephritis  |  |   |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |  | (C) DUE TO, OR AS A CONSEQUENCE OF:   |  |   |  |
| 19A. DATE OF OPERATION  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)   |  |
|   |  |   |  | No  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |  | 21E. INJURY OCCURRED  |  | 21F. HOW DID INJURY OCCUR?  |  |
|   |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from October 19, 1969 to October 29, 1969 that (I) (we) last saw the deceased alive on October 29, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |   |  |   |  |
| 23A. SIGNATURE  |  | M.D. DEGREE   |  | 23B. DATE SIGNED  |  |
| [Signature]   |  |   |  | 10-29-69  |  |
| 23C. PHYSICIAN'S NAME (Type)  |  | 23D. ADDRESS  |  |   |  |
| OITENGO   |  | 1514 Division Street Balto., Maryland   |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |  | 24B. DATE   |  | 24C. NAME OF CEMETERY OR CREMATORY  |  |
| Burial  |  | 11/1/69   |  | Mt. Auburn  |  |
| 25A. DATE REC'D BY HEALTH DEPT.   |  | 25B. NAME OF REGISTRAR  |  | 25C. FUNERAL DIRECTOR   |  |
| NOV 3 1969  |  | Robert E. Seiber, M.D.  |  | [Signature]   |  |
|   |  |   |  | ADDRESS   |  |
|   |  |   |  | 1727 N. Newcast   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |   |  |
|---|--|---|--|
| <div style="display: flex; justify-content: space-between;"> <span>1-120</span> <span>69 10771</span> <span>CERTIFICATE OF DEATH</span> </div>  |  | REG. NO. <span style="font-size: 1.2em;">69 10771</span>  |  |
| BIRTH NO.   |  | 2. DATE AND HOUR OF DEATH   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <i>DAVIS, ANNA Bell</i>  |  | <i>10-31-69 4:30 A.M.</i>   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)                                       |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>Bolton Hill Nursing Home</i>   |  | A. STATE <i>MARYland</i> B. COUNTY <i>1801</i>  |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |  | C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 5. SEX <i>F.</i> 6. RACE <i>N.</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <i>10-2-1911</i> 9. AGE (In years last birthday) <i>58</i>   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>   |  | 11. BIRTHPLACE (State or foreign country) <i>Bucksport So. Carolina</i>   |  |
| 10B. KIND OF BUSINESS OR INDUSTRY   |  | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME <i>Not known Sam McFall</i>   |  | 14. MOTHER'S MAIDEN NAME <i>Camille White</i>   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>  |  | 16. SOCIAL SECURITY NO. <i>248-18-9139</i>  |  |
| 17. INFORMANT <i>Bolton Hill Nursing Home</i>   |  | ADDRESS   |  |
| 18. <i>412.21</i> CAUSE OF DEATH  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6/23/69</i>   |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>cardiac thrombosis</i>   |  |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  |  | (B) <i>Hypertension, C.V. disease</i> years   |  |
| ANTECEDENT CAUSES   |  | (C) <i>arteriosclerosis generalized</i> years   |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |  |   |  |
| II  |  |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (A)  |  |   |  |
| 19A. DATE OF OPERATION  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20A. AUTOPSY? (Yes or No)   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                    |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |   |  |
| 21D. TIME OF INJURY (Approx.)   |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                      |  |
| 21F. HOW DID INJURY OCCUR?  |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>7/15</i> 19 <i>69</i> to <i>10/31</i> 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>10/31</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |   |  |
| 23A. SIGNATURE <i>ALLAN H. MORTIMER</i>   |  | 23B. DATE SIGNED <i>10/31/69</i>  |  |
| 23C. PHYSICIAN'S NAME (Type) <i>ALLAN H. MORTIMER</i>   |  | 23D. ADDRESS <i>2 E Pearl St Pkx Md 1100</i>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |  | 24B. DATE   |  |
| <i>Burial 11/3/69</i>   |  | <i>11/3/69</i>  |  |
| 24C. NAME OF CEMETERY OR CREMATORY <i>St. Calvary Cem.</i>  |  | 24D. LOCATION (City, town, or county) (State) <i>Bethesda Md.</i>   |  |
| 25A. DATE REC'D BY HEALTH DEPT. <i>NOV 3 1969</i>   |  | 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>  |  |
| 25C. FUNERAL DIRECTOR <i>Williams Funeral Home</i>  |  | ADDRESS <i>3191 Schenck St</i>  |  |





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| B-652 69 10772   |                  |   |  | BALTIMORE CITY HEALTH DEPARTMENT  |   | REG. NO. 69 10772   |  |
|--|------------------|---|--|---|---|---|--|
| BIRTH NO.  |                  |   |  | BALTIMORE CITY HEALTH DEPARTMENT  |   |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Audrey Barnes</b>  |                  |   |  | 2. DATE AND HOUR OF DEATH<br><b>November 1, 1969 11:00 A.M.</b>   |   |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>38 Barnes University of Md. Hosp.<br/>22 S. Greene St.<br/>Baltimore, Md. 21201</b>  |                  |   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>2101</b><br>C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>208 Otterbein St</b> |   |   |  |
| 5. SEX <b>M.F.</b>   | 6. RACE <b>C</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>3/29/07</b>   | 9. AGE (In years lost birthday) <b>62</b> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                       |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>   |                  |   |  | 10B. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>                 |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |                  |   |  | 13. FATHER'S NAME <b>George Taylor</b>  |   |   |  |
| 14. MOTHER'S MAIDEN NAME <b>Liziel</b>   |                  |   |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |   |   |  |
| 16. SOCIAL SECURITY NO. <b>219-189493</b>  |                  |   |  | 17. INFORMANT <b>Ben Barnes 208 Otterbein St</b>  |   |   |  |
| 18. <b>250.01</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Hypoglycemic reaction</b><br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>probable</b> |                  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>hours</b>   |   |   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Arteriosclerotic Cerebral</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Diabetes Mellitus</b><br>(C)  |                  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years</b>   |   |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>Ch. Pylorophiditis</b>  |                  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>year</b>  |   |   |  |
| 19A. DATE OF OPERATION <b>2</b>  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No) <b>Yes</b>  |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b> |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?  |   |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                 |                  |   |  |   |   |   |  |
| 23A. SIGNATURE <b>Rifat Aboway</b>   |                  |   |  | 23B. DATE SIGNED <b>11-2-69</b>   |   |   |  |
| 23C. PHYSICIAN'S NAME (Type) <b>Rifat Aboway</b>   |                  |   |  | 23D. ADDRESS <b>Un of Md hospital</b>   |   |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>   |                  | 24B. DATE <b>11/5/69</b>  |  | 24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn</b>   |   | 24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>               |  |
| 25A. DATE REC'D BY HEALTH DEPT. <b>NOV 3 1969</b>  |                  | 25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>  |  | 25C. FUNERAL DIRECTOR <b>Charles A. Rice</b>  |   | ADDRESS <b>661 W. Borne St</b>  |  |



BALTIMORE CITY HEALTH DEPARTMENT

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

BIRTH NO. 69-13378 REG. NO. 69 10773

**1. NAME OF DECEASED** (Type or Print) KAREN L. GIVENS

**2. DATE OF DEATH** Known ☒ Estimated ☐ Month October Day 30 Year 1969 Hour 8:35 A. M.

**3. DATE PRONOUNCED DEAD** Month October Day 30 Year 1969 Hour 8:35 A. M.

**4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD** (Name of hospital, nursing home, or institution, or address or location) Bon Secours Hospital 11/13/69

**5. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland B. COUNTY 1604

**6. SEX** Female **7. RACE** Negro **8. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

**9. DATE OF BIRTH** 7-28-69 **10. AGE** (In years) 3 **11. BIRTHPLACE** (State or foreign country) Maryland **12. CITIZEN OF WHAT COUNTRY?** U.S.A. **13. FATHER'S NAME** George Pearson

**14A. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired) none **14B. KIND OF BUSINESS OR INDUSTRY** none **15. MOTHER'S MAIDEN NAME** Evon Givens

**16. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no or unknown) (If yes, give war or dates of service) no **17. SOCIAL SECURITY NO.** Evon Givens 1835 Edmondson Ave. **18. INFORMANT** Evon Givens **ADDRESS** 1835 Edmondson Ave.

**19. CAUSE OF DEATH** 484X **DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** Early pneumonitis  
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) **(A) IMMEDIATE CAUSE** Sudden death in infancy  
DUE TO, OR AS A CONSEQUENCE OF:  
**(B)** DUE TO, OR AS A CONSEQUENCE OF:  
**(C)** DUE TO, OR AS A CONSEQUENCE OF:

**II**  
**OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).**

**20A. DATE OF OPERATION** 2 **20B. CONDITION FOR WHICH OPERATION WAS PERFORMED** Yes **21. AUTOPSY? (Yes or No)** Yes

**22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.** ☐ **22B. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? **22C. WHERE DID (If in Baltimore City, give exact location)** INJURY OCCUR?

**22D. TIME OF INJURY (APPROX.)** (Month) (Day) (Year) (Hour) 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ **22F. HOW DID INJURY OCCUR?**

**23. I certify that I held on** Inquiry ☐ Inspection ☐ Autopsy ☒ **and that on this basis, death in my opinion resulted from:** Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

**ACTUAL SIGNATURE** Charles S. Springate, M.D. **CHIEF MEDICAL EXAMINER** ☐ **DATE SIGNED** October 30, 1969  
**EXAMINER'S NAME (Type)** Charles S. Springate, M.D. **ASSISTANT MEDICAL EXAMINER** ☒ **ASSOCIATE MEDICAL EXAMINER** ☐

**24A. BURIAL CREMATION, REMOVAL (Specify)** Burial **24B. DATE** 11-3-69 **24C. NAME OF CEMETERY or CREMATORY** Mt. Auburn **24D. LOCATION** (City, town, or county) (State) Baltimore, Maryland

**25A. DATE REC'D BY HEALTH DEPT.** NOV 3 1969 **25B. NAME OF REGISTRAR** Robert E. Taylor, M.D. **25C. FUNERAL DIRECTOR** Charles A. Rice **ADDRESS** 661 W. Barre St.

Letter from Dr. Springate dated 11/11/69

C-432 69 10774 BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** REG. NO. 69 10774

BIRTH NO.

|   |  |  |  |
|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>MILTON E. CHILDS</b>   |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month Day Year Hour<br><b>10 25 69 8:54 PM</b> |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>43 South Balto. General Hospital</b> |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>Oct. 25, 1969 8:54 p.m.</b>   |  |
| 6. SEX<br><b>Male</b>   |  | 7. RACE<br><b>Negro</b>  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                     |  | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>2543</b>            |  |
| 9. DATE OF BIRTH<br><b>6-6-49</b>   |  | 10. AGE (In years last birthday)<br><b>20</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Factory Worker</b>  |  | 14B. KIND OF BUSINESS OR INDUSTRY  |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |  | 17. SOCIAL SECURITY NO.  |  |
| 18. INFORMANT<br><b>Odessa Childs</b>   |  | ADDRESS<br><b>2447 Maisel Ct.</b>  |  |

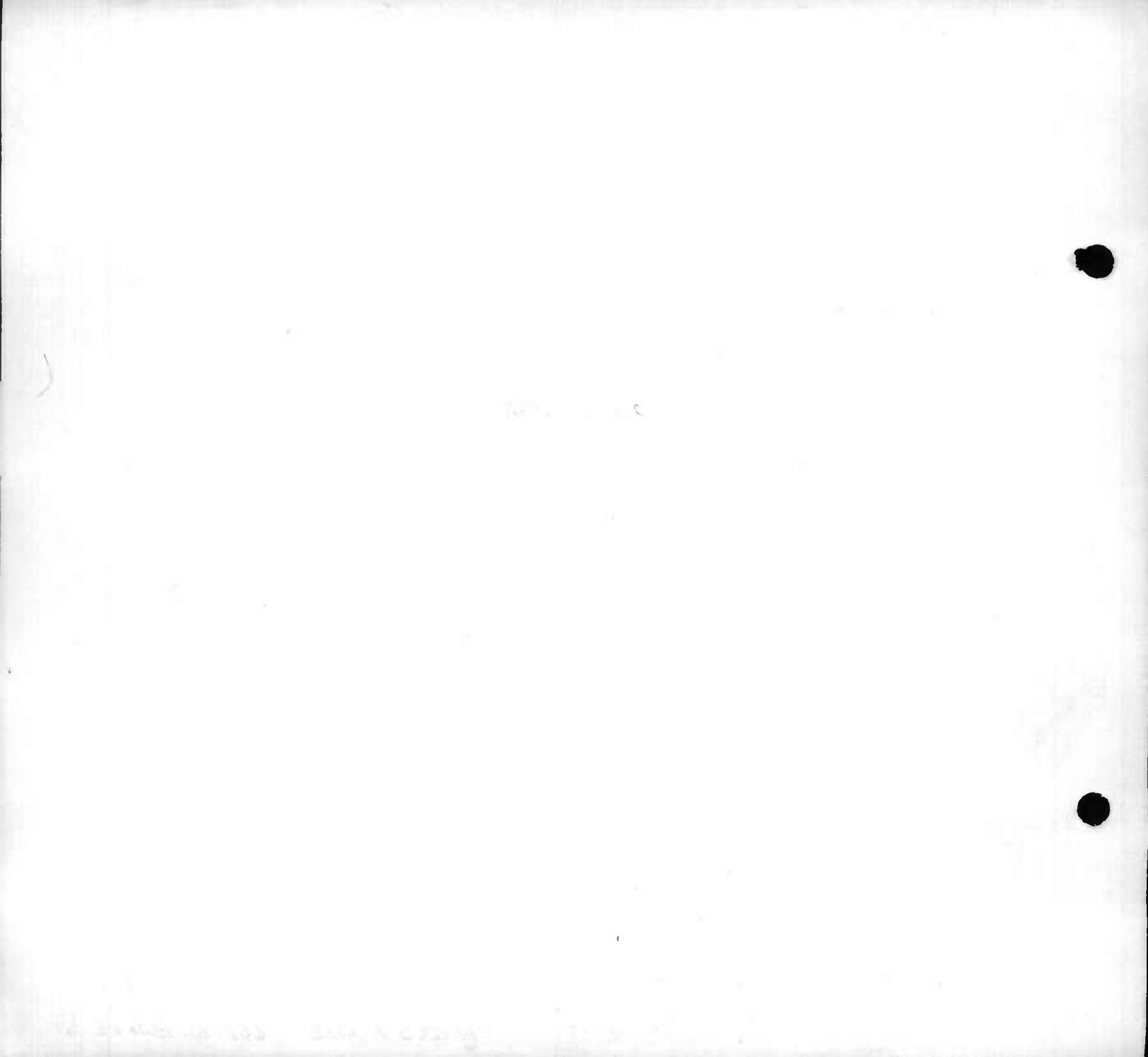
|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 19. <b>E 9651X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <b>Gunshot wound of the right chest and abdomen</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) _____<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |   |  |   |  |
| 20A. DATE OF OPERATION<br><b>21</b>   |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 21. AUTOPSY? (Yes or No)<br><b>YES</b>  |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.  |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Tavern</b>   |  | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br><b>Jack-A-Lou Tavern 2426 Hollins Ferry Rd.</b> |  |
| 22D. TIME OF INJURY (APPROX.)<br>Month (Day) (Year) (Hour)<br><b>10 25 69 8:30p</b>   |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  | 22F. HOW DID INJURY OCCUR?<br><b>Subject, during altercation, was shot</b>  |  |
| 23.<br>I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/><br><br>ACTUAL SIGNATURE <b>Isidore Mihalakis, M.D.</b> M.D.<br>EXAMINER'S NAME (Type)<br><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED <b>10/26/69</b> |  |   |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 24B. DATE<br><b>10-31-69</b>  |  | 24C. NAME of CEMETERY or CREMATORY<br><b>Mt. Auburn</b>   |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>   |  |   |  |   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 3 1969</b>  |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor Jr.</b>   |  | 25C. FUNERAL DIRECTOR<br><b>Charles A. Rice</b>   |  |
|   |  |   |  | ADDRESS<br><b>661 W. Barre St.</b>  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

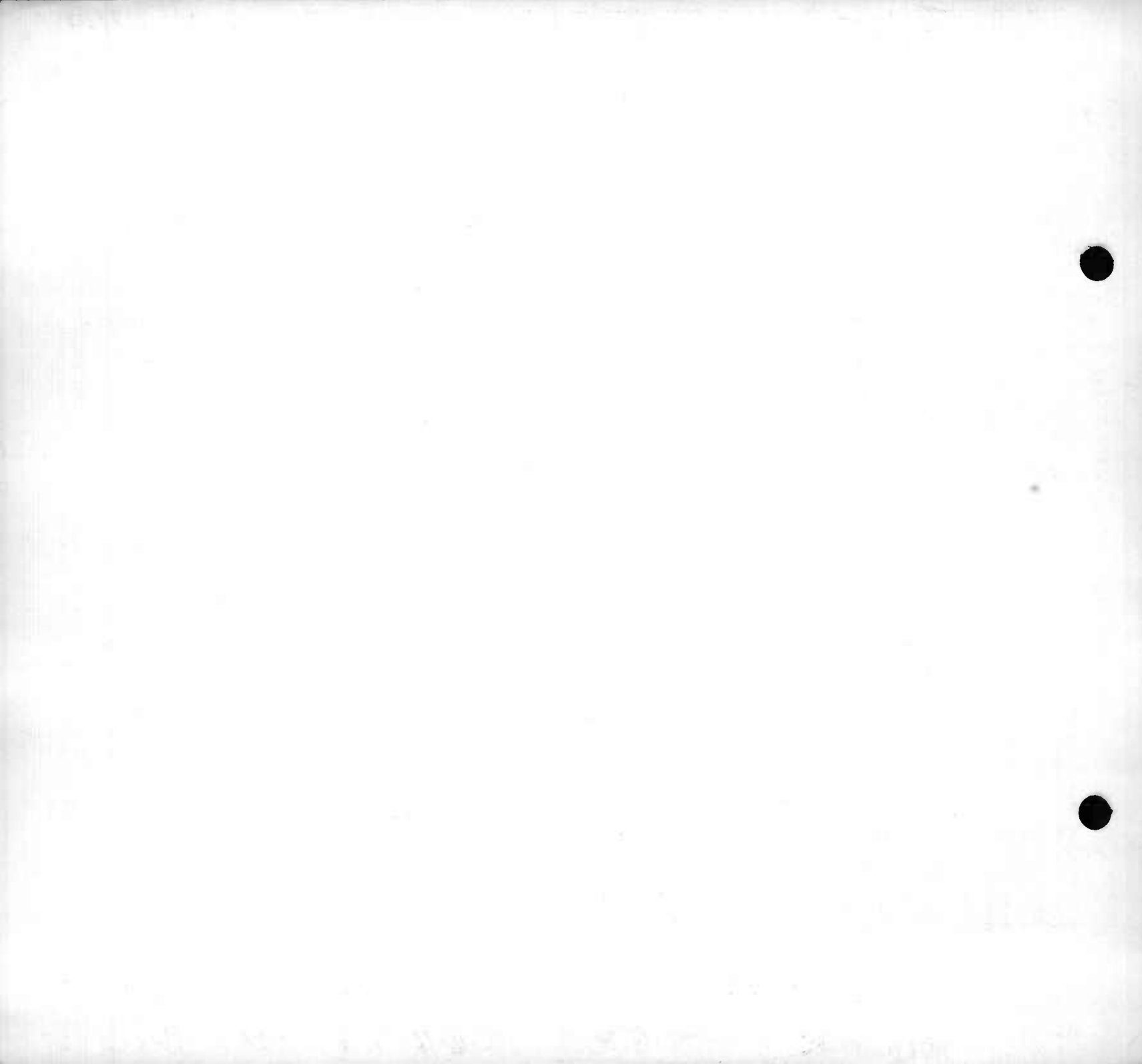
| BIRTH NO. 69 10775  |                     |   |   | BALTIMORE CITY HEALTH DEPARTMENT   |  | CERTIFICATE OF DEATH  |  | REG. NO. 69 10775  |  |  |
|---|---------------------|---|---|--|--|---|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <u>Ronnie Gamble</u>   |                     |   |   | 2. DATE AND HOUR OF DEATH<br><u>10-30-69</u> <u>8:20 P</u> M.  |  |   |  |  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                     |   |   | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>MD</u> B. COUNTY <u>2101</u>                            |  |   |  |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>38 University of Md Hosp</u>  |                     |   |   | C. CITY OR TOWN<br><u>Baltimore</u>  |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |
|   |                     |   |   | E. STREET AND NUMBER<br><u>301 S. Fremont Ave</u>  |  |   |  |  |  |  |
| 5. SEX<br><u>M</u>  | 6. RACE<br><u>N</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>10-27-24</u>   |  | 9. AGE (In years last birthday)<br><u>44 yrs</u> | If Under 1 Yr. Months Days Hours Min.   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>LABORER</u> |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                     |   | 10B. KIND OF BUSINESS OR INDUSTRY   |  |  | 11. BIRTHPLACE (State or foreign country)   |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u> |  |
| 13. FATHER'S NAME<br><u>Gussie Harrison</u>   |                     |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Angie Gamble</u>  |  |   |  |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |                     |   | 16. SOCIAL SECURITY NO.<br><u>248-32-6822</u>   |  | 17. INFORMANT<br><u>Roselee Gamble - Wife</u>    |   |  |  | ADDRESS                                    |  |
| 18. <u>410.91x303</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                     |   |   | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><u>Brain stem infarction</u><br>(B) <u>Acute Myocardial infarction</u><br>(C) _____ |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>4 days</u><br><u>4 days</u>                               |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><u>Chronic Alcoholism</u>   |                     |   |   |  |  |   |  |  |  |  |
| 19A. DATE OF OPERATION<br><u>2</u>  |                     |   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20A. AUTOPSY? (Yes or No)<br><u>Yes</u>   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><u>Yes</u>                           |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |                     |   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                   |  |  |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                     |   | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  |  | 21F. HOW DID INJURY OCCUR?  |  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10-26</u> 19 <u>69</u> to <u>10-30</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>10-30</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                     |   |   |  |  |   |  |  |  |  |
| 23A. SIGNATURE<br><u>Paul R. S. S. M.D.</u>   |                     |   |   |  |  | 23B. DATE SIGNED<br><u>10-30-69</u>   |  | 23C. PHYSICIAN'S NAME (Type)<br><u>DEGREE</u>  |  |  |
| 23D. ADDRESS<br><u>DEGREE</u>   |                     |   |   |  |  | 23E. FUNERAL DIRECTOR<br><u>CHARLES A. RICE</u>   |  |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |                     | 24B. DATE<br><u>11/4/69</u>   |   | 24C. NAME of CEMETERY or CREMATORY<br><u>Baltimore National</u>  |  | 24D. LOCATION (City, town, or county) (State)<br><u>Baltimore MD</u>                          |  |  |  |  |
| 25A. DATE RECEIVED BY HEALTH DEPT.<br><u>NOV 3 1969</u>   |                     | 25B. NAME OF REGISTRAR<br><u>Robert E. Talley, M.D.</u>   |   | 25C. FUNERAL DIRECTOR ADDRESS<br><u>661 W. BARRE ST.</u>   |  |   |  |  |  |  |





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |         |  |                  |   |                            |  |  |
|---|---------|--|------------------|---|----------------------------|--|--|
| T-425   |         | 69 10776   |                  | BALTIMORE CITY HEALTH DEPARTMENT  |                            | 69 10776   |  |
| BIRTH NO.   |         |  |                  | REG. NO.  |                            |  |  |
| 1. NAME OF DECEASED<br>Type or Print  |         |  |                  | 2. DATE AND HOUR OF DEATH   |                            |  |  |
| EDITH TILGHMAN  |         |  |                  | 10/31/69 112.30 a.m.  |                            |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |         |  |                  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) |                            |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION  |         |  |                  | A. STATE<br>B. COUNTY   |                            |  |  |
| UNIVERSITY OF MARYLAND HOSPITAL   |         |  |                  | MARYLAND 2102   |                            |  |  |
|   |         |  |                  | C. CITY OR TOWN   |                            | D. INSIDE CITY LIMITS?   |  |
|   |         |  |                  | BALTIMORE   |                            | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
|   |         |  |                  | E. STREET AND NUMBER  |                            |  |  |
|   |         |  |                  | 615 ARCHER ST. 21230  |                            |  |  |
| 5. SEX  | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>               | 8. DATE OF BIRTH | 9. AGE (In years lost birthday)   | If Under 1 Yr. Months Days |  |  |
| FEMALE  | NEGRO   | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>            | 5/17/98          | 71  |                            |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |         | 10B. KIND OF BUSINESS OR INDUSTRY  |                  | 11. BIRTHPLACE (State or foreign country)   |                            | 12. CITIZEN OF WHAT COUNTRY?   |  |
| HOUSEWIFE   |         |  |                  | MARYLAND  |                            | U.S.A.   |  |
| 13. FATHER'S NAME   |         |  |                  | 14. MOTHER'S MAIDEN NAME  |                            |  |  |
| WILTON TYLER  |         |  |                  | MARY BARNES   |                            |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |         | 16. SOCIAL SECURITY NO.  |                  | 17. INFORMANT ADDRESS   |                            |  |  |
| UNKNOWN   |         |  |                  | MARTHA NORRIS, 764 W. HAMBURG ST.   |                            |  |  |
| 18. CAUSE OF DEATH  |         |  |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                            |  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |         |  |                  | INTESTINAL VOLVULUS   |                            |  |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  |         |  |                  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                   |                            |  |  |
| ANTECEDENT CAUSES   |         |  |                  | OBSTRUCTION   |                            |  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |         |  |                  | (B) DUE TO, OR AS A CONSEQUENCE OF:   |                            |  |  |
|   |         |  |                  | TWO WEEKS   |                            |  |  |
| II  |         |  |                  |   |                            |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |         |  |                  | CARDIAC ARREST & ACUTE RENAL FAILURE  |                            |  |  |
| 19A. DATE OF OPERATION  |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                  | 20A. AUTOPSY? (Yes or No)   |                            | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
|   |         |  |                  |   |                            |  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)   |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |                            |  |  |
|   |         |  |                  |   |                            |  |  |
| 21D. TIME OF INJURY (APPROX.)   |         | 21E. INJURY OCCURRED   |                  | 21F. HOW DID INJURY OCCUR?  |                            |  |  |
| 1 Month 1 Day 1 Year 1 Hour   |         | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |                  |   |                            |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 10/27/1969 to 10/31/1969 that (I) (we) last saw the deceased alive on 10/31/1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |         |  |                  |   |                            |  |  |
| 23A. SIGNATURE  |         |  |                  | 23B. DATE SIGNED  |                            |  |  |
| Andrew M. Doyle   |         |  |                  | 10/31/69  |                            |  |  |
| 23C. PHYSICIAN'S NAME (Type)  |         |  |                  | 23D. ADDRESS  |                            |  |  |
|   |         |  |                  |   |                            |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |         | 24B. DATE  |                  | 24C. NAME of CEMETERY or CREMATORY  |                            | 24D. LOCATION (City, town, or county) (State)                        |  |
| BURIAL  |         | 11/4/69  |                  | Baltimore National  |                            | Baltimore, Md.   |  |
| 25A. DATE REC'D BY HEALTH DEPT.   |         | 25B. NAME OF REGISTRAR   |                  | 25C. FUNERAL DIRECTOR ADDRESS   |                            |  |  |
| NOV 2 1969  |         | Robert E. Fisher, M.D.   |                  | CHARLES A. RICE 661 W. BARRE ST.  |                            |  |  |



69 10777

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 10777

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)HOWARD / W.  
DARE2. DATE OF DEATH  
Known ☒ Month Day Year Hour  
Estimated ☐ 10 31 69 10:05 a.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  
OR INSTITUTION

Union Memorial Hospital D.O.A.

3. DATE PRONOUNCED DEAD  
Month Day Year Hour  
Oct. 31, 1969 10:05 a.5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

6-2-1905

10. AGE (In years  
last birthday)

64

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

3828 Kimble Rd.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Thomas Dare

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Post Office Service Gov't.

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Elizabeth Hoos

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

218-18-3341

18. INFORMANT

Iola V. Dare

ADDRESS

Above

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., In or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Isidore Mihalakis, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/31/69

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

11-4-69

24C. NAME OF CEMETERY or CREMATORY

Moreland Memorial

24D. LOCATION (City, town, or county)

Balto. Co.

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

NOV 3 1969

25B. NAME OF REGISTRAR

Robert E. Talley, M.D.

25C. FUNERAL DIRECTOR

H.W. Jenkins &amp; Sons Co., Balto., Md.

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69 10778 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 10778

BIRTH NO.

|  |  |  |  |  |     |  |                          |
|--|--|--|--|--|-----|--|--------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>ALICE GOCHENAUR</b>  |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Estimated <input type="checkbox"/>                          |  | Month  | Day | Year   | Hour                     |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>1508 E. Balto. Street (DOA)</b> |  | 3. DATE PRONOUNCED DEAD<br><b>November 2, 1969</b>   |  | Month  | Day | Year   | Hour<br><b>9:07 A.M.</b> |
| 6. SEX<br><b>Female</b>  |  | 7. RACE<br><b>White</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |     | C. CITY OR TOWN<br><b>Baltimore</b>  |                          |
| 9. DATE OF BIRTH<br><b>Jan. 10, 1912</b>   |  | 10. AGE (In years lost birthday)<br><b>57</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>E. Liverpool, Ohio</b>   |     | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                          |
| 13. FATHER'S NAME<br><b>Albert Houser</b>  |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b> |  | 15. MOTHER'S MAIDEN NAME<br><b>Carrie Chapman</b>  |     | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                 |                          |
| 17. SOCIAL SECURITY NO.  |  | 18. INFORMANT<br><b>Dawson Funeral Home</b>  |  | 19. ADDRESS<br><b>215 W. Fifth St. E. Liverpool, Ohio</b>  |     | 20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |                          |
| 19. CAUSE OF DEATH<br><b>Cirrhosis of Liver</b>  |  | 21. IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:   |  | 22. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |     | 23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |                          |
| 20A. DATE OF OPERATION   |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 21. AUTOPSY? (Yes or No)<br><b>no</b>  |     | 22. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                  |                          |
| 22A. TIME (Month) (Day) (Year) (Hour)<br>(APPROX.)   |  | 22B. PLACE OF INJURY (e.g., in or about home, room, factory, street, office bldg., etc.)                       |  | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?   |     | 22D. HOW DID INJURY OCCUR?   |                          |
| 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 22F. HOW DID INJURY OCCUR?   |  | 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |     | 24. ACTUAL SIGNATURE<br><b>Ronald N. Kornblum, M.D.</b>  |                          |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Rem. Burial</b>   |  | 24B. DATE<br><b>11/5/69</b>  |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Riverview</b>   |     | 24D. LOCATION (City, town, or county) (State)<br><b>E. Liverpool, Ohio</b>   |                          |
| 25A. DATE RECEIVED BY HEALTH DEPT.<br><b>NOV 3 1969</b>  |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Seabury, M.D.</b>   |  | 25C. FUNERAL DIRECTOR<br><b>H. W. Jenkins &amp; Sons Co.</b>   |     | 25D. ADDRESS<br><b>4905 York Rd. Baltimore, Md. 21212</b>  |                          |

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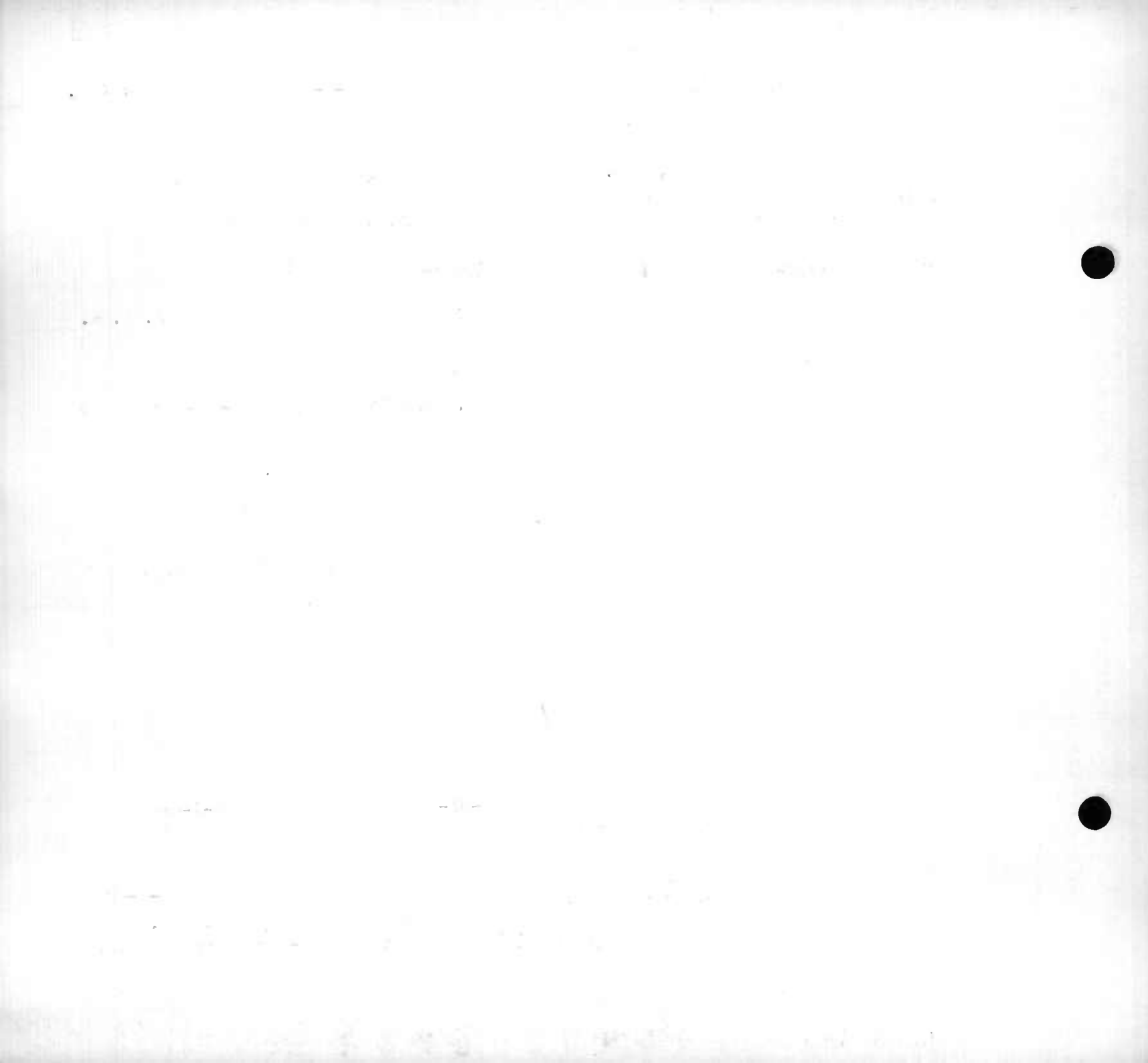
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |  |  |  | REG. NO. <b>69 10779</b>  |
|--|--|--|--|---|
| M-420  |  | 69 10779   |  | CERTIFICATE OF DEATH  |
| BIRTH NO.  |  | 1. NAME OF DECEASED<br>(Type or Print) <b>Alice Mills</b>  |  |   |
| 2. DATE AND HOUR OF DEATH<br><b>11-1-69</b>  |  | 8:25 p/ M.   |  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>1304</b> |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>39</b><br><b>Provident Hospital, Inc.</b><br><b>1514 Division Street</b><br><b>Baltimore, Maryland 21217</b>  |  | C. CITY OR TOWN<br><b>Baltimore</b>  |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |
| 5. SEX<br><b>Female</b>  |  | 6. RACE<br><b>Negro</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH<br><b>10-26-17</b>  |  | 9. AGE (In years last birthday)<br><b>52</b>   |  | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Unemployed</b>   |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 13. FATHER'S NAME<br><b>Robert Semine</b>  |  |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Minnie Coleman</b>  |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                   |  |   |
| 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><b>Mrs. Anna Coleman (Sister-in-Law)</b> ADDRESS <b>Same</b>  |  |   |
| 18. CAUSE OF DEATH<br><b>412.2 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>[This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.]<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| 19A. DATE OF OPERATION   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)<br><b>No</b>  |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                          |  |   |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)  |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)  |  |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>I APPROX.   |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                  |  | 21F. HOW DID INJURY OCCUR?  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10-31-69</b> to <b>11-1-69</b> that (I) (we) lost saw the deceased alive on <b>11-1-69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |  |  |  |   |
| 23A. SIGNATURE<br><b>G. Teneco</b>   |  | 23B. DATE SIGNED<br><b>11-2-69</b>   |  | 23C. PHYSICIAN'S NAME (Type)<br><b>G. Teneco</b>  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>Nov. 6/69</b>  |  | 24C. NAME of CEMETERY or CREMATORY<br><b>Bald Hill Cem.</b>   |
| 24D. LOCATION<br><b>5501 Fredrick Ave</b>  |  | 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 3 1969</b>   |  |   |
| 25B. NAME OF REGISTRAR<br><b>J. E. J. J.</b>   |  | 25C. FUNERAL DIRECTOR<br><b>Joseph E. J. J.</b>  |  |   |
| 25D. ADDRESS<br><b>1129 N. Center St</b>   |  |  |  |   |





1 **G-650** 69 10780 BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** REG. NO. **69 10780**

|   |                         |   |   |   |   |
|---|-------------------------|---|---|---|---|
| BIRTH NO.   |                         | 1. NAME OF DECEASED<br>(Type or Print) <b>NATHANIEL GREEN</b>   |   | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> M.   |   |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>In Water W.side of Pier #3, Pratt Street</b>   |                         | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>October 31, 1969 2:10 P. M.</b>  |   | 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>704</b>  |   |
| 6. SEX<br><b>Male</b>   | 7. RACE<br><b>Negro</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. CITY OR TOWN<br><b>Baltimore</b>                 |   | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 9. DATE OF BIRTH<br><b>March 27, 1931</b>   |                         | 10. AGE (In years last birthday) <b>38</b>  | E. STREET AND NUMBER<br><b>1723 E. Eager Street</b> |   |   |
| 11. BIRTHPLACE (State of foreign country)<br><b>Md.</b>   |                         | 12. CITIZEN OF WHAT COUNTRY?  | 13. FATHER'S NAME<br><b>Quincy Allen</b>            |   |   |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>   |                         | 14B. KIND OF BUSINESS OR INDUSTRY   | 15. MOTHER'S MAIDEN NAME<br><b>Eva Green</b>        |   |   |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)   |                         | 17. SOCIAL SECURITY NO.   | 18. INFORMANT<br><b>Nathaniel Green</b> ADDRESS     |   |   |
| 19. <b>E 984X</b>   |                         | CAUSE OF DEATH  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  |                         | Drowning  |   |   |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |                         | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:  |   |   |   |
|   |                         | (B) DUE TO, OR AS A CONSEQUENCE OF:   |   |   |   |
|   |                         | (C) DUE TO, OR AS A CONSEQUENCE OF:   |   |   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |                         |   |   |   |   |
| 20A. DATE OF OPERATION<br><b>2</b>  |                         | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 21. AUTOPSY? (Yes or No)<br><b>yes</b>  |   |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                         | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>? Water</b>  |   | 22C. WHERE DID INJURY OCCUR?<br><b>Pier #3</b>  |   |
| 22D. TIME OF INJURY (APPROX.) <b>Oct. 1969</b>  |                         | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |   | 22F. HOW DID INJURY OCCUR?<br><b>Subject found floating near Pier #3 (Pratt Street)</b>   |   |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> |                         | ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>11/1/69</b> |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 24B. DATE<br><b>Nov 5/69</b>  |   | 24C. NAME OF CEMETERY or CREMATORY<br><b>Mt Auburn Cems</b>   |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>Westport Md.</b>  |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 3 1969</b>  |   | 25B. NAME OF REGISTRAR<br><b>Robert E. Taiter, M.D.</b>   |   |
| 25C. FUNERAL DIRECTOR<br><b>Joseph T. Glickman</b>  |                         | ADDRESS<br><b>1129 N. Carroll St</b>  |   |   |   |

OK 01 89

OK 01 89

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VALLEY

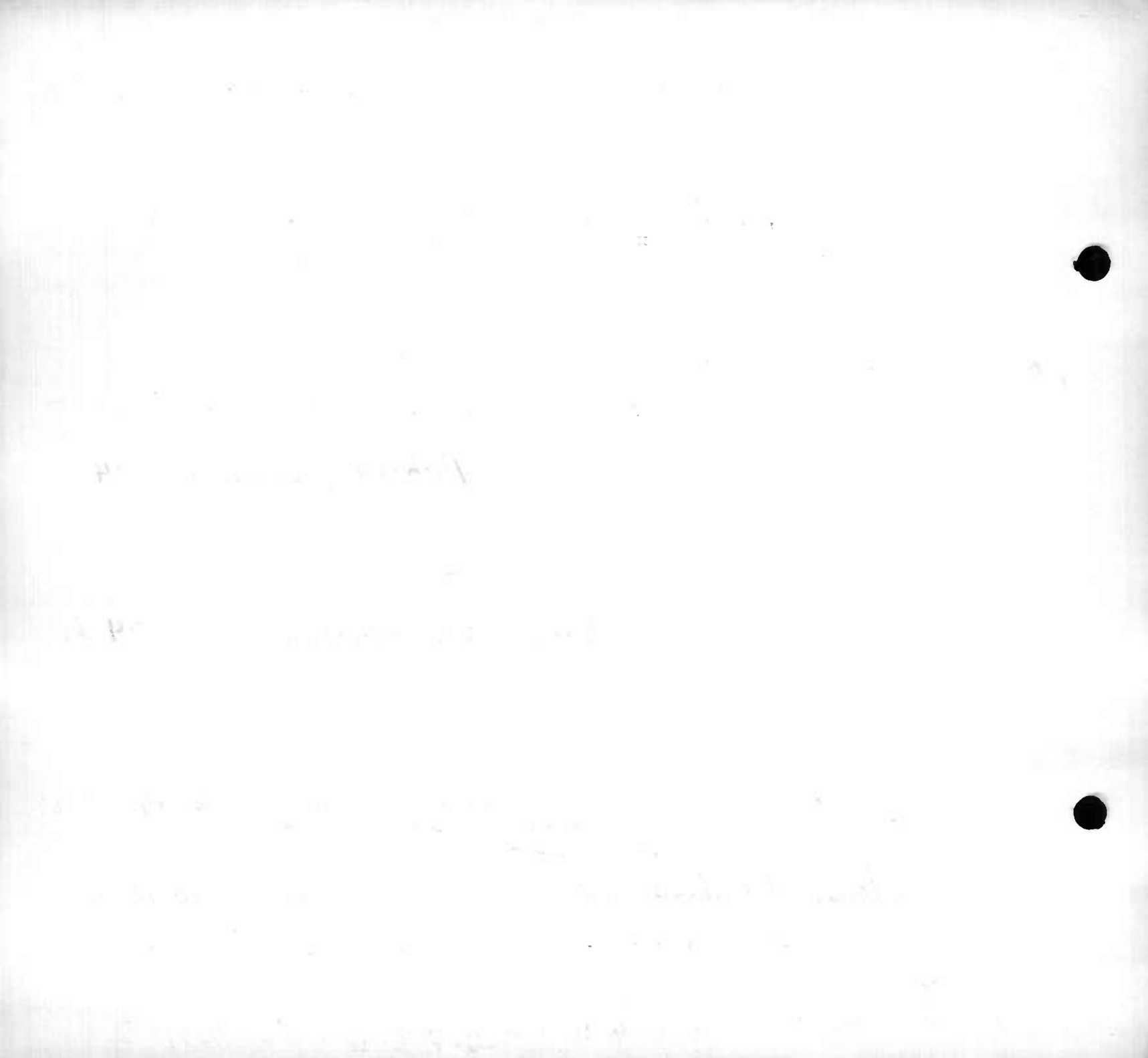
VALLEY

OK 01 89

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

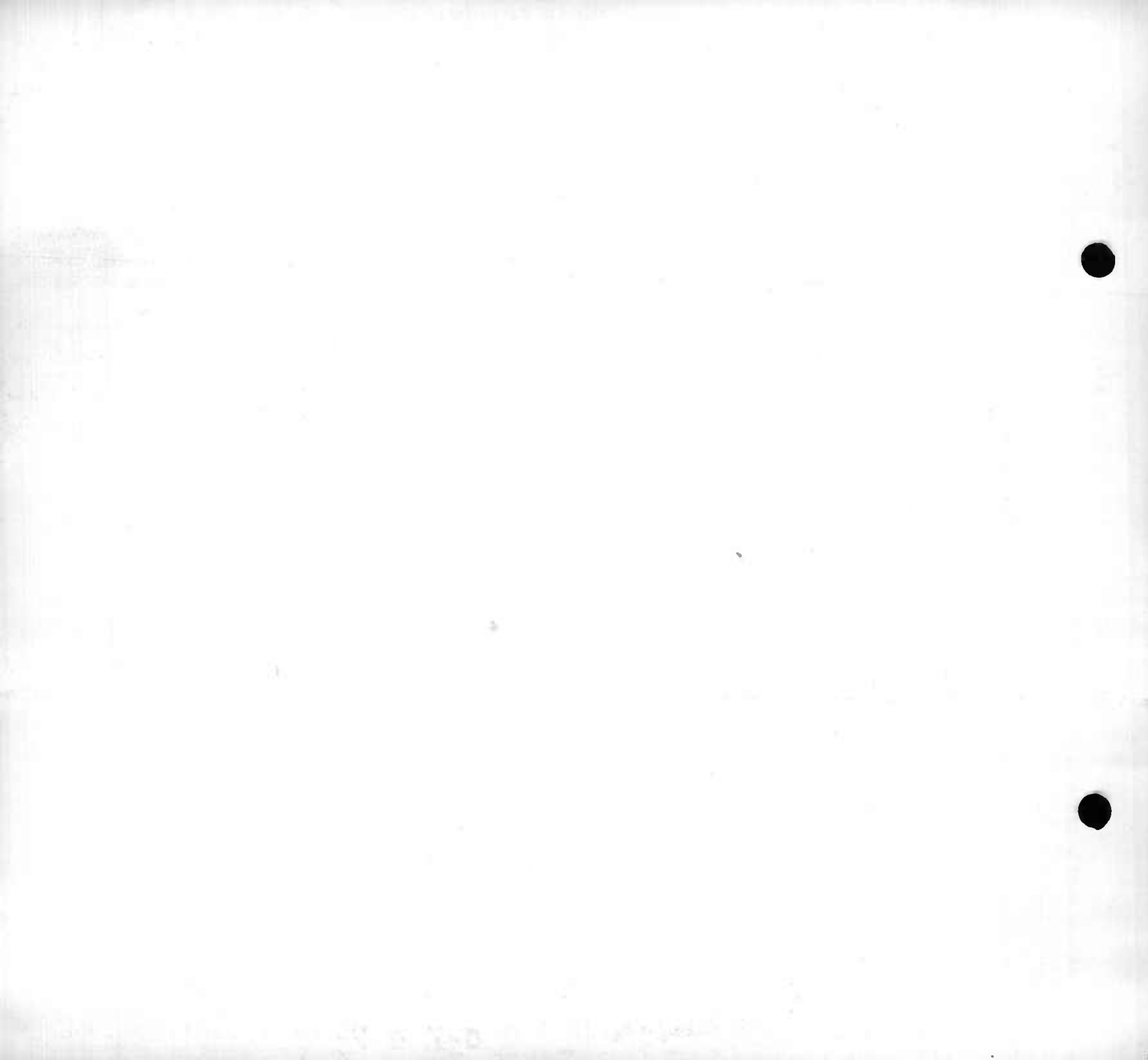
|  |                  |   |  |  |                                       |  |  |
|--|------------------|---|--|--|---------------------------------------|--|--|
| B-423  |                  | 69 10781  |  | CITY HEALTH DEPARTMENT   |                                       | REG. NO. 69 10781  |  |
| BIRTH NO.  |                  |   |  | 1. NAME OF DECEASED<br>(Type or Print) Hydie Blackstone  |                                       |  |  |
| 2. DATE AND HOUR OF DEATH<br>10.29.69 2:10 A.M.  |                  |   |  |  |                                       |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>Baltimore City Hospitals<br>4940 Eastern Ave.<br>31 Baltimore, Maryland 21224   |                  |   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE Maryland<br>B. COUNTY 10-01<br>C. CITY OR TOWN Baltimore<br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER 1228 Aisquith St. 21205 007 |                                       |  |  |
| 5. SEX<br>Male   | 6. RACE<br>Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>4-18-99  | 9. AGE (In years last birthday)<br>70 | 10. If Under 1 Yr. Months: Days: 11. If Under 24 Hrs. Hours: Min.    |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Retired   |                  |   |  | 10B. KIND OF BUSINESS OR INDUSTRY  |                                       | 11. BIRTHPLACE (State or foreign country)<br>Va.                     |  |
| 12. CITIZEN OF WHAT COUNTRY?   |                  |   |  |  |                                       |  |  |
| 13. FATHER'S NAME<br>George Blackstone   |                  |   |  | 14. MOTHER'S MAIDEN NAME<br>Barbra   |                                       |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |                  |   |  | 16. SOCIAL SECURITY NO.<br>213-01-3693   |                                       | 17. INFORMANT<br>BCH Records: 4940 Eastern Ave. 21224                |  |
| 18. 486 X I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br>Possible acute brain syndrome |                  |   |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>Probable pneumonia<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:   |                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>> 4 wks<br>> 4 wks   |  |
| 19A. DATE OF OPERATION<br>2  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br>Yes   |                                       | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                                       |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?   |                                       |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 10.1.1969 to 10.29.1969 that (I) (we) last saw the deceased alive on 10.29.1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                  |   |  |  |                                       |  |  |
| 23A. SIGNATURE<br>James J. Corkins MD  |                  |   |  | 23B. DATE SIGNED<br>10.29.69   |                                       | 23C. PHYSICIAN'S NAME (Type)<br>James J. Corkins, M.D.               |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial   |                  |   |  | 24B. DATE<br>Nov 1/69  |                                       | 24C. NAME OF CEMETERY OR CREMATORY<br>Mt Auburn Cem.                 |  |
| 24D. LOCATION (City, town, or county) (State)<br>Westport Md.  |                  |   |  | 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 3 1969  |                                       |  |  |
| 25B. NAME OF REGISTRAR<br>Robert E. Taylor   |                  |   |  | 25C. FUNERAL DIRECTOR<br>Barnett E. Elchman  |                                       |  |  |
| 25D. ADDRESS<br>1129 D. Curran St  |                  |   |  |  |                                       |  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| N-132  |  | 69 10782  |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | REG. NO. 69 10782   |  |
| BIRTH NO.  |  |   |  | 1. NAME OF DECEASED<br>(Type or Print) <b>WALTER NOVITSKY</b>  |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |   |  | 2. DATE AND HOUR OF DEATH<br><b>10-26-69 11:15 AM</b>  |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>CHARLOT HONE &amp; HOSPITAL</b><br><b>100 N. BROADWAY, BALTO, MD</b>  |  |   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD</b> B. COUNTY <b>806</b> |  |   |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |  |   |  | C. CITY OR TOWN<br><b>BALTIMORE</b>  |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |
| 5. SEX <b>M</b> 6. RACE <b>W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |   |  | 8. DATE OF BIRTH<br><b>8-19-09</b>   |  | 9. AGE (In years last birthday) <b>60</b>   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>CONFECTIONARY STORE OWNER</b>  |  |   |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><b>PA.</b>   |  |
| 13. FATHER'S NAME<br><b>JACOB NOVITSKY</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>MARY TROTSKOSITA (TROTSKY)</b>  |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>?</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>220057500</b>  |  | 17. INFORMANT<br><b>PATIENT</b> S. NAME: <b>HR. ROSE REED</b> ADDRESS: <b>121 Ridge Ave Coatsville Pa</b> |  |
| 18. <b>441.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>RUPTURED AORTIC ANEURYSM</b>   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 DAYS</b>  |  |   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |  |   |  | (B) <b>ATHEROSCLEROSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF:  |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>ACUTE TUBERCULAR NECROSIS</b><br><b>EMPHYSEMA</b>   |  |   |  | 3 DAYS   |  |   |  |
| 19A. DATE OF OPERATION<br><b>10-22-69</b>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>LEAKING AORTIC ANEURYSM</b>                        |  | 20A. AUTOPSY? (Yes or No)  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                      |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><b>P.A.</b>   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>N.A.</b>   |  | 21C. WHERE DID INJURY OCCUR?<br><b>N.A.</b>  |  | (If in Baltimore City, give exact location)   |  |
| 21D. TIME OF INJURY (APPROX.)<br><b>P.A.</b>   |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?<br><b>N.A.</b>  |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10-21-69</b> 19 to <b>10-26</b> 19 <b>69</b> that (I) (we) last saw the deceased alive on <b>10-26-69</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 23A. SIGNATURE<br><b>Richard M. Tuason M.D.</b>  |  |   |  |  |  | 23B. DATE SIGNED<br><b>10-26-69</b>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>RICHARD M. TUASON M.D.</b>  |  |   |  |  |  | 23D. ADDRESS<br><b>100 N. BROADWAY ST BALTO, MD.</b>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>10-31-69</b>  |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Holy Rosary Cem</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>Dundalk, Md.</b>                                      |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 3 1969</b>   |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>   |  | 25C. FUNERAL DIRECTOR<br><b>Galbreath Funeral Home</b>   |  | ADDRESS<br><b>2007 Eastern Ave 21231</b>  |  |

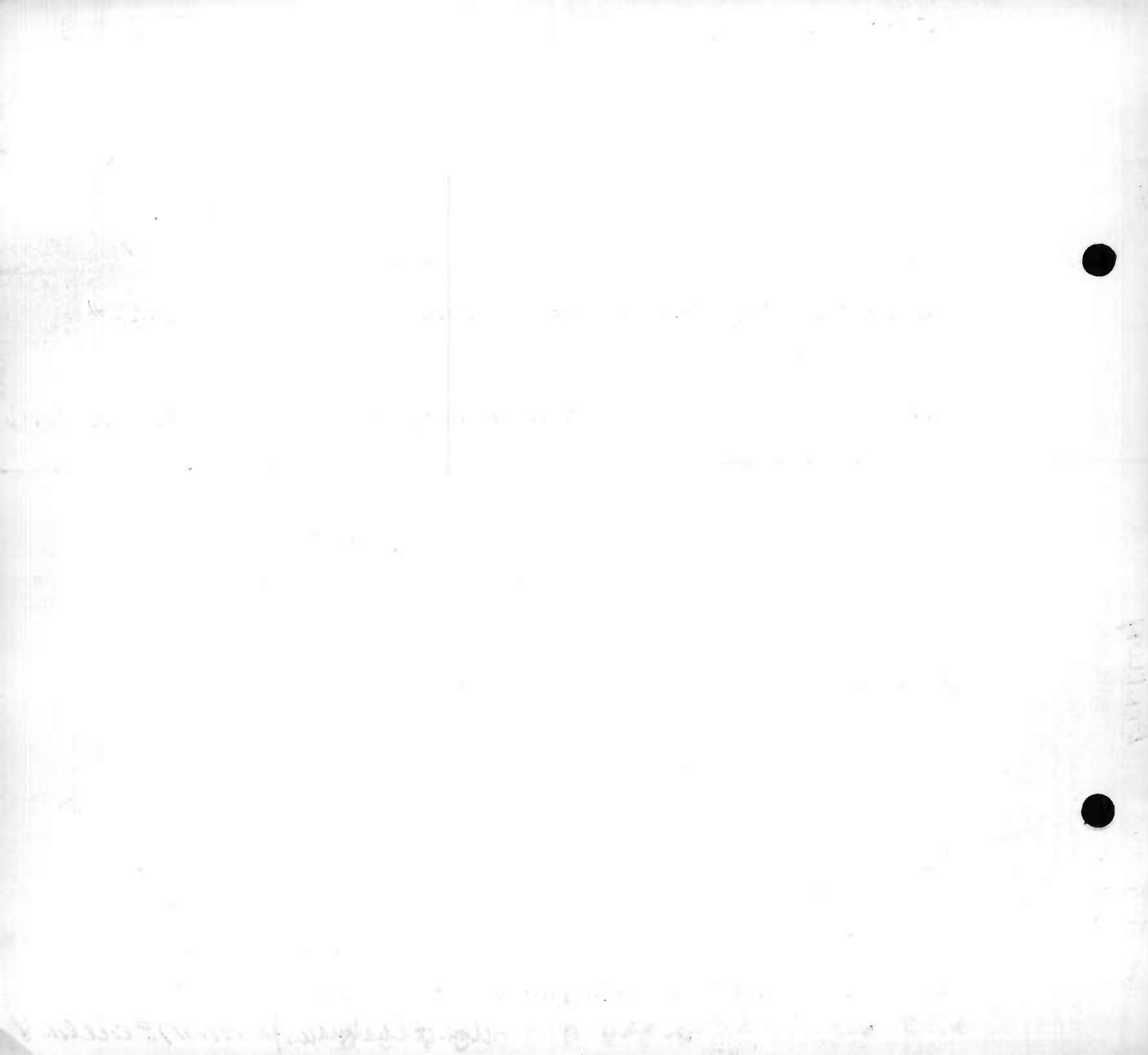


RECEIVED BY DR. KOENBLUM

FUNERAL DIRECTOR: IMPORTANT

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| L-166   |                         | 69 10783  |                                     | BALTIMORE CITY HEALTH DEPARTMENT  |                            | REG. NO. 69 10783                                       |  |
|---|-------------------------|---|-------------------------------------|---|----------------------------|---|--|
| BIRTH NO.   |                         |   |                                     | 1. NAME OF DECEASED<br>(Type or Print) <u>LABORD, Herman</u>  |                            |   |  |
| 2. DATE AND HOUR OF DEATH<br><u>10.31.69</u> <u>8:15 P</u> M.   |                         |   |                                     | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                            |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>33</u> THE JOHNS HOPKINS HOSPITAL  |                         |   |                                     | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE CITY</u> <u>2716</u> |                            |   |  |
| C. CITY OR TOWN <u>BALTIMORE</u>  |                         |   |                                     | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                            |   |  |
| E. STREET AND NUMBER <u>2855 EDGECOMB CIRCLE N.</u>   |                         |   |                                     |   |                            |   |  |
| 5. SEX<br><u>MALE</u>   | 6. RACE<br><u>NEGRO</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>10-24-23</u> | 9. AGE (in years lost birthday)<br><u>46</u>  | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.                             |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>CEMENT FINESHER</u>   |                         |   |                                     | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>contractors</u>   |                            | 11. BIRTHPLACE (State or foreign country)<br><u>MD.</u> |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |                         |   |                                     | 13. FATHER'S NAME<br><u>BRACY LABORARD</u>  |                            |   |  |
| 14. MOTHER'S MAIDEN NAME<br><u>MARIE</u>  |                         |   |                                     | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>NO</u>   |                            |   |  |
| 16. SOCIAL SECURITY NO.<br><u>UNKNOWN</u>   |                         |   |                                     | 17. INFORMANT<br><u>JANET (LABORD)</u> <u>2855 EDGECOMB CIRCLE</u>  |                            |   |  |
| 18. <u>441.0 I</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>II</u><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |                         |   |                                     | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><u>MASSIVE HEMORRHAGE</u>   |                            |   |  |
|   |                         |   |                                     | (B) <u>RUPTURE OF DISSECTING ACUTE AORTIC ANEURYSM</u><br>DUE TO, OR AS A CONSEQUENCE OF:   |                            |   |  |
|   |                         |   |                                     | (C) <u>ATHEROSCLEROTIC CARDIOVASC. DISEASE</u>  |                            |   |  |
| 19A. DATE OF OPERATION<br><u>10.31.69</u>   |                         |   |                                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                            |   |  |
| 20A. AUTOPSY? (Yes or No)<br><u>YES</u>   |                         |   |                                     | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                            |   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)   |                         |   |                                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                            |   |  |
| 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |                         |   |                                     | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                            |   |  |
| 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                         |   |                                     | 21F. HOW DID INJURY OCCUR?  |                            |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10.31</u> 19 <u>69</u> to <u>10.31</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>10.31</u> 19 <u>69</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                         |   |                                     |   |                            |   |  |
| 23A. SIGNATURE<br><u>Dr. Lerberg, M.D.</u>  |                         |   |                                     | 23B. DATE SIGNED<br><u>10.31.69</u>   |                            |   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>H. LERBERG</u>   |                         |   |                                     | 23D. ADDRESS<br><u>THE JOHNS HOPKINS HOSPITAL</u>   |                            |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |                         |   |                                     | 24B. DATE<br><u>11/5/69</u>   |                            |   |  |
| 24C. NAME of CEMETERY or CREMATORY<br><u>Arboretum Mtn. P.K.</u>  |                         |   |                                     | 24D. LOCATION (City, town, or county) (State)<br><u>Balco. Md.</u>  |                            |   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 3 1969</u>  |                         |   |                                     | 25B. NAME OF REGISTRAR<br><u>Robert E. Taylor</u>   |                            |   |  |
| 25C. FUNERAL DIRECTOR<br><u>Wm. J. Chatain, Jr. - 1701 M</u>  |                         |   |                                     | ADDRESS<br><u>2855 Edgecomb Circle</u>  |                            |   |  |

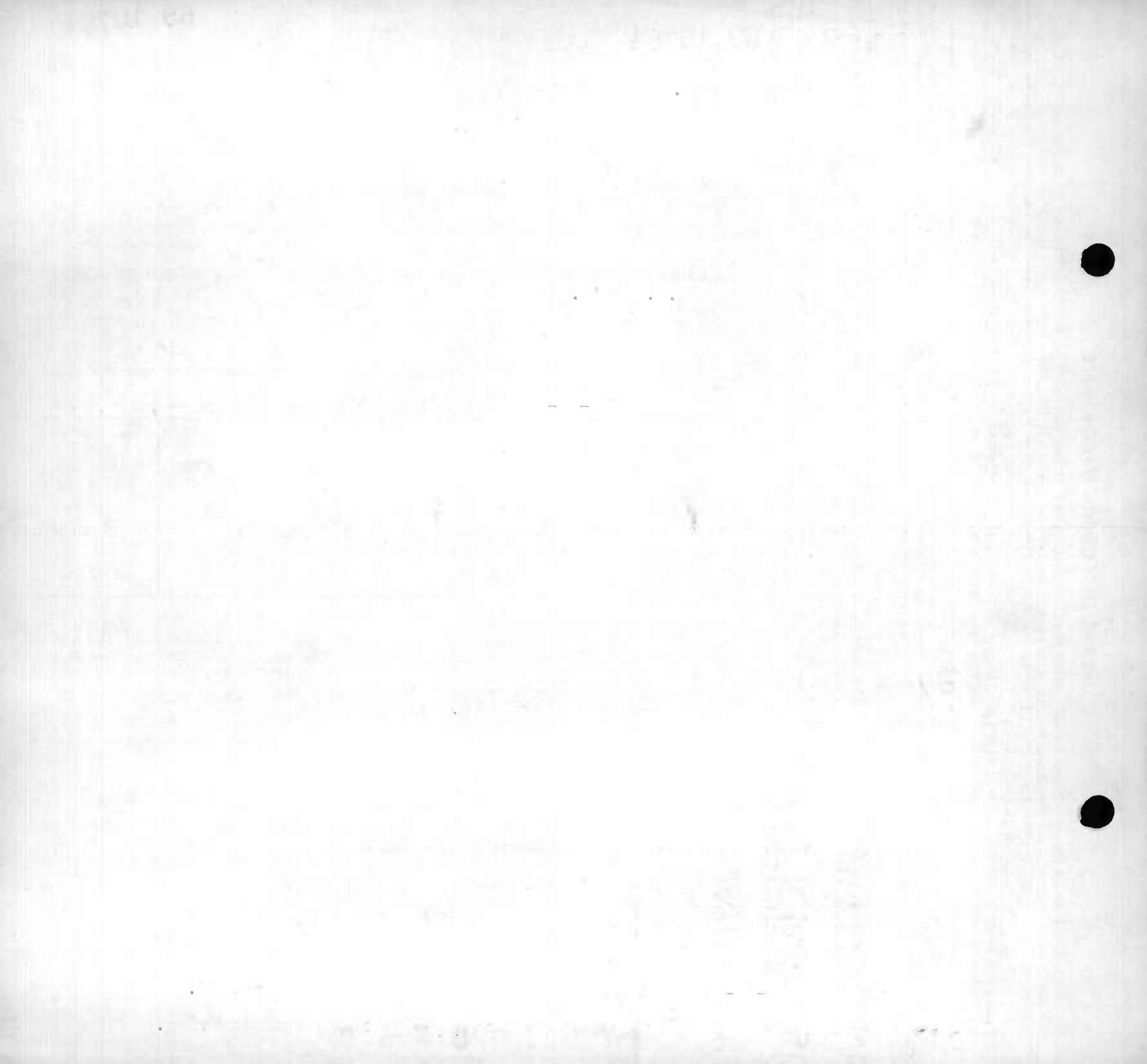




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |  |   |  | REG. NO. <b>69 10784</b>  |  |
|---|--|---|--|---|--|
| 8-263   |  | 69 10784  |  | CERTIFICATE OF DEATH  |  |
| BIRTH NO.   |  | 1. NAME OF DECEASED<br>(Type or Print) <i>Charles H. Richardson</i>   |  | 2. DATE AND HOUR OF DEATH<br><i>10/27/69 11 50 AM</i>   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <i>MD.</i> B. COUNTY <i>Balt.</i> |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>Union Memorial</i>   |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><i>33 - E. Calvert St. Balt., Md.</i>                       |  | C. CITY OR TOWN<br><i>Balt.</i>   |  |
| 44  |  |   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 5. SEX<br><i>M</i>  |  | 6. RACE<br><i>W</i>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>retired Mailman</i>   |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>U.S. Gov't.</i>   |  | 8. DATE OF BIRTH<br><i>5-29-05</i>  |  |
| 13. FATHER'S NAME<br><i>Charles H. Richardson</i>   |  | 14. MOTHER'S MAIDEN NAME<br><i>Mary Ebersole</i>  |  | 9. AGE (In years last birthday)<br><i>64</i>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>No</i>   |  | 16. SOCIAL SECURITY NO.<br><i>213-05-7585</i>   |  | 17. INFORMANT<br><i>Lillian Kellenbeck Richardson, wife, above</i>  |  |
| 18. <i>492X-150X</i>  |  | CAUSE OF DEATH  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><i>Respiratory arrest</i>   |  | <i>8 hrs.</i>   |  |
| ANTECEDENT CAUSES   |  | (B) DUE TO, OR AS A CONSEQUENCE OF:<br><i>Emphysema</i>   |  | <i>2 weeks</i>  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |  | (C) <i>Emphysema</i>  |  | <i>1 mo?</i>  |  |
| II  |  | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).    |  | (MM)  |  |
| 19A. DATE OF OPERATION<br><i>10-2, 10-17</i>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Ca of Emphysema</i>  |  | 20A. AUTOPSY? (Yes or No)<br><i>Yes</i>   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                           |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9/24/69</i> to <i>10/27/69</i> , that (I) (we) last saw the deceased alive on <i>10/27/69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |   |  |   |  |
| 23A. SIGNATURE<br><i>Frank J. Gillen MD</i>   |  | 23B. DATE SIGNED<br><i>10-27-69</i>   |  | 23C. PHYSICIAN'S NAME (Type)<br><i>FRANK J. GILLEN, M.D.</i>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |  | 24B. DATE<br><i>10-30-69</i>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Western Cemetery</i>   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>NOV 3 1969</i>  |  | 25B. NAME OF REGISTRAR<br><i>Robert E. Hader, REC'D</i>   |  | 25C. FUNERAL DIRECTOR<br><i>Schimunek Funeral Home, Inc.</i>  |  |
|   |  |   |  | ADDRESS<br><i>3331 Brehms Lane</i>  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

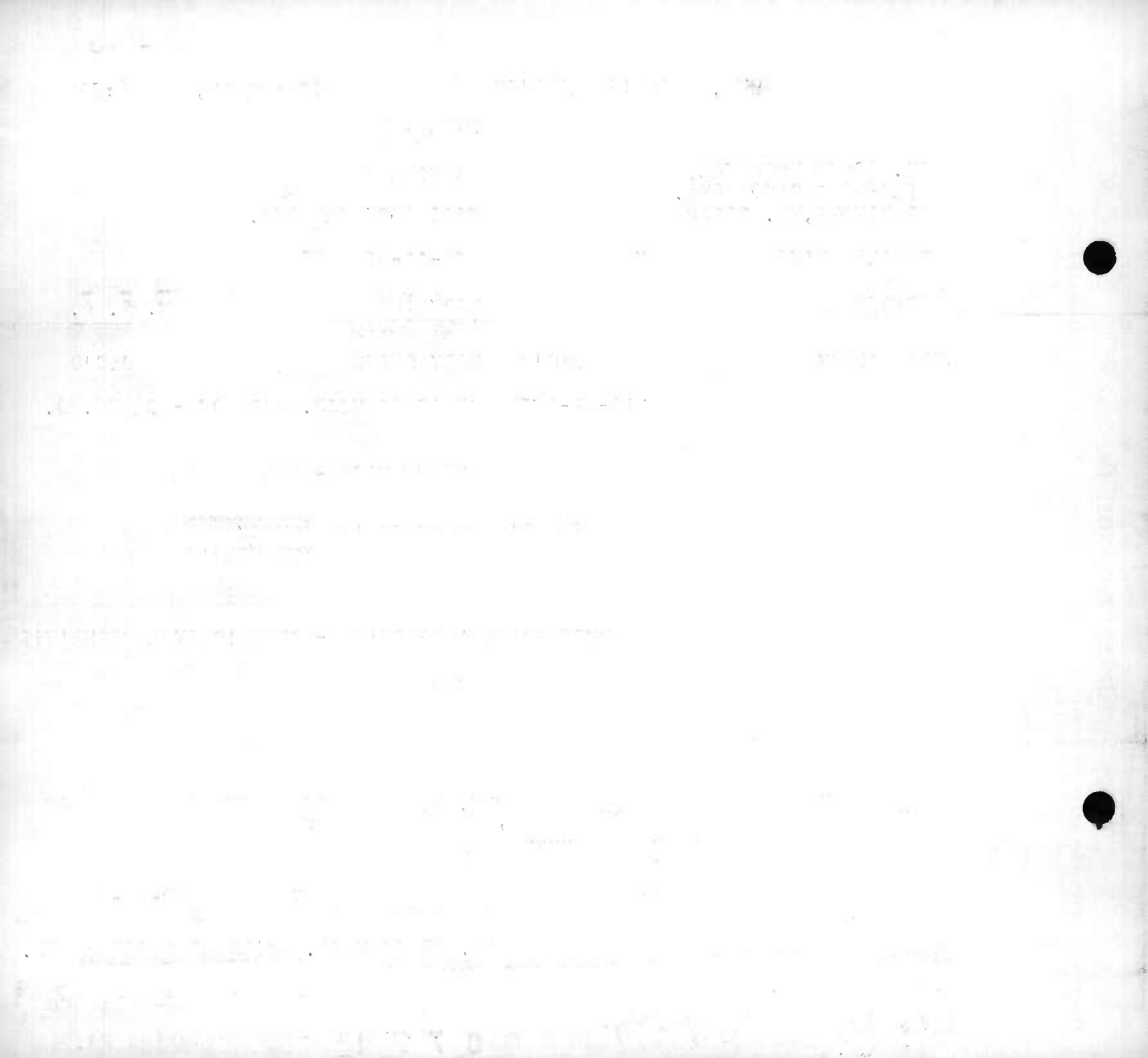
|   |  |          |  |  |  |                   |  |
|---|--|----------|--|--|--|-------------------|--|
| B-451   |  | 69 10785 |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | REG. NO. 69 10785 |  |
| BIRTH NO.   |  |          |  | 1. NAME OF DECEASED<br>(Type or Print) <b>Vyca E. Blamble</b>                            |  |                   |  |
| 2. DATE AND HOUR OF DEATH<br><b>10-31-69 4:15A. M.</b>  |  |          |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                   |  |                   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>HARBOR VIEW NURSING CENTER</b>   |  |          |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                     |  |                   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  |          |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b>                                     |  |                   |  |
| 15. SEX<br><b>Female</b>  |  |          |  | 16. RACE<br><b>White</b>   |  |                   |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |          |  | 8. DATE OF BIRTH<br><b>6/20/82</b>   |  |                   |  |
| 9. AGE (In years last birthday)<br><b>87</b>  |  |          |  | 10. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |                   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  |          |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |                   |  |
| 13. FATHER'S NAME<br><b>John Biggs</b>  |  |          |  | 14. MOTHER'S MAIDEN NAME<br><b>Moreland</b>  |  |                   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  |          |  | 16. SOCIAL SECURITY NO.<br><b>213-54-3392</b>  |  |                   |  |
| 17. INFORMANT (Son)<br><b>Mr. George B. Blamble,</b>  |  |          |  | ADDRESS<br><b>1515 Elrino St. Balto. Md. 21224</b>                                       |  |                   |  |
| 18. CAUSE OF DEATH<br><b>412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |  |          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                   |  |
| 19A. DATE OF OPERATION<br><b>0</b>  |  |          |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |                   |  |
| 20A. AUTOPSY? (Yes or No)<br><b>No</b>  |  |          |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                     |  |                   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |  |          |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  |                   |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |          |  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)                                |  |                   |  |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  |          |  | 21F. HOW DID INJURY OCCUR?   |  |                   |  |
| 22. I certify that (this hospital) attended the deceased from <b>5-13 1969</b> to <b>10-31 1969</b> , that (we) lost saw the deceased alive on <b>10-31 1969</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |  |          |  |  |  |                   |  |
| 23A. SIGNATURE<br><b>MANUEL A. GONGON, M.D.</b>   |  |          |  | 23B. DATE SIGNED<br><b>10-31-69</b>  |  |                   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>MANUEL A. GONGON, M.D.</b>   |  |          |  | 23D. ADDRESS<br><b>5701 THE ALAMEDA, BALTO. MD. 21212</b>                                |  |                   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |          |  | 24B. DATE<br><b>11/3/69</b>  |  |                   |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Red House Lutheran Church Cem.</b>   |  |          |  | 24D. LOCATION (City, town, or county) (State)<br><b>Oakland, Garrett Co. Maryland</b>    |  |                   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 3 1969</b>  |  |          |  | 25B. NAME OF REGISTRAR<br><b>John O. Durst</b>   |  |                   |  |
| 25C. FUNERAL DIRECTOR<br><b>John O. Durst</b>   |  |          |  | ADDRESS<br><b>Oakland, Maryland</b>  |  |                   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

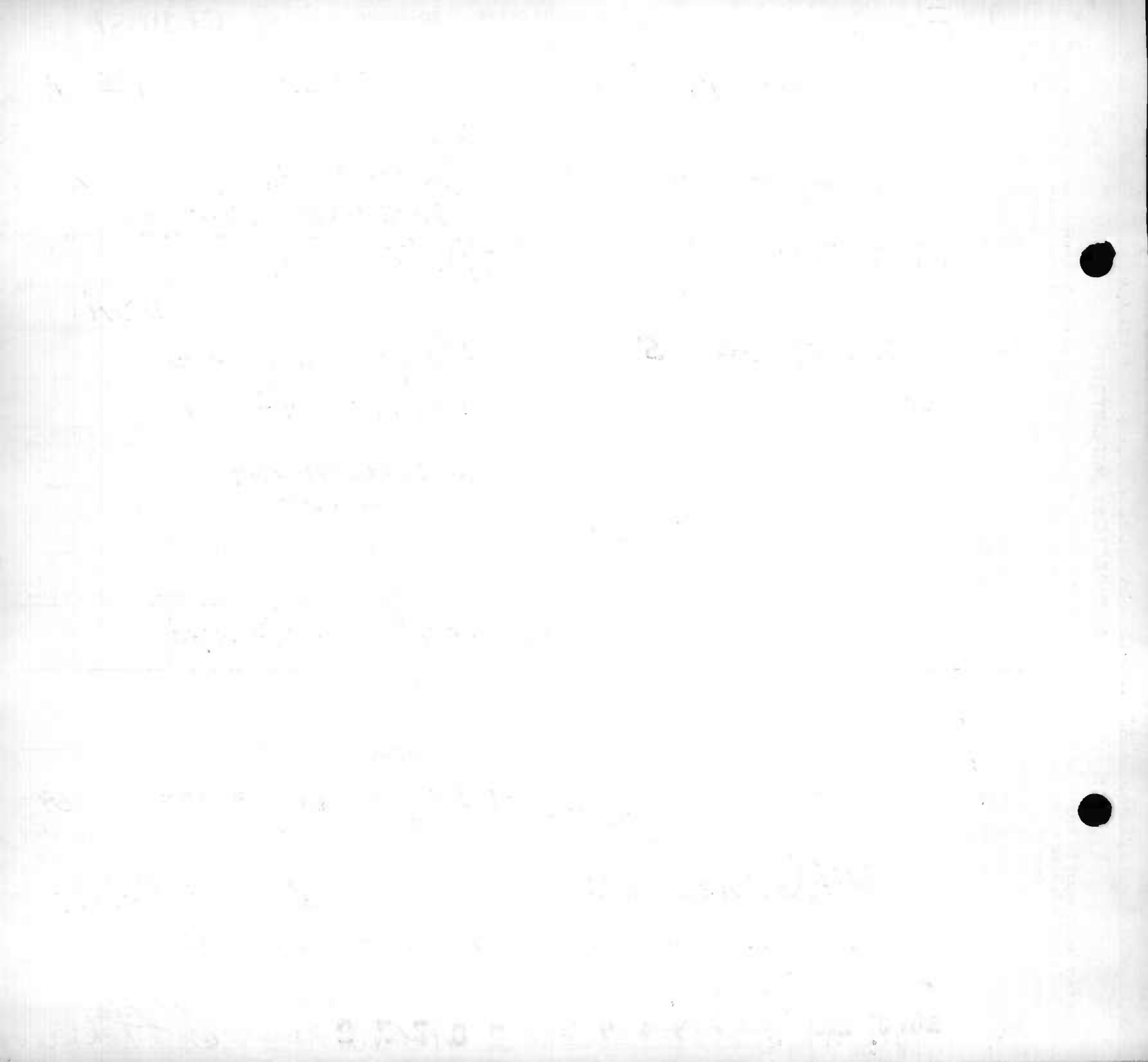
| BIRTH NO. <u>D-500</u>  |                         |  |                                     | BALTIMORE CITY HEALTH DEPARTMENT   |  | REG. NO. <u>69 10786</u>  |  |
|---|-------------------------|--|-------------------------------------|--|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <u>DEHNE, ANNIE LILLIAN</u>  |                         |  |                                     | 2. DATE AND HOUR OF DEATH<br><u>OCTOBER 27, 69</u> <u>6:53P</u> M.                                   |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                         |  |                                     | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)                 |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>ST. AGNES HOSPITAL</u><br><u>WILKENS &amp; CATON AVE.</u><br><u>BALTIMORE, MD. 21228</u>  |                         |  |                                     | A. STATE<br><u>MARYLAND</u>  |  | B. COUNTY<br><u>BALTO. CO.</u>  |  |
|   |                         |  |                                     | C. CITY OR TOWN<br><u>BALTIMORE</u>  |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
|   |                         |  |                                     | E. STREET AND NUMBER<br><u>2111 ROCKWELL AVE.</u>  |  |   |  |
| 5. SEX<br><u>FEMALE</u>   | 6. RACE<br><u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>07-12-93</u> | 9. AGE (In years last birthday)<br><u>76</u>   | II Under 1 Yr. Months: Days: Hours: Min. | II Under 24 Hrs. Min.   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>RETIRED</u>   |                         | 10B. KIND OF BUSINESS OR INDUSTRY  |                                     | 11. BIRTHPLACE (State or foreign country)<br><u>MARYLAND</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>                                     |  |
| 13. FATHER'S NAME<br><u>OTIS CLARK</u>  |                         |  |                                     | 14. MOTHER'S MAIDEN NAME<br><u>MARY SMITH</u>  |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service)  |                         | 16. SOCIAL SECURITY NO.<br><u>214-01-7008</u>  |                                     | 17. INFORMANT<br><u>ST AGNES HOSP. RECORDS</u>   |  |   |  |
|   |                         |  |                                     | ADDRESS<br><u>BALTO. MD.</u>   |  |   |  |
| 18. <u>44421</u> CAUSE OF DEATH   |                         |  |                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><u>HEMORRHAGE - SMALL BOWEL</u>   |                         |  |                                     | <u>24 hrs.</u>   |  |   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>SUPERIOR MESENTERICK ARTERY</u>  |                         |  |                                     | <u>indefinite</u>  |  |   |  |
|   |                         |  |                                     | <u>THROMBOSIS</u>  |  |   |  |
|   |                         |  |                                     |  |  |   |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><u>FRIG. HUMERUS</u>   |                         |  |                                     | <u>MYOCARDIAL INFARCTION - CHRONIC PYELONEPHRITIS</u>  |  |   |  |
| 19A. DATE OF OPERATION<br><u>2</u>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                     | 20A. AUTOPSY? (Yes or No)<br><u>YES</u>  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><u>yes</u>  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><u>home</u>  |                                     | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><u>2111 Rockwell Ave</u> |  |   |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)<br><u>10-26-69</u>  |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>   |                                     | 21F. HOW DID INJURY OCCUR?<br><u>Slipped on stairs, Fell</u>   |  |   |  |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>OCT. 27</u> 19 <u>69</u> to <u>OCT 27</u> 19 <u>69</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>OCTOBER 27</u> , 19 <u>69</u> and that <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death. |                         |  |                                     |  |  |   |  |
| 23A. SIGNATURE<br><u>G. Patrick M.D.</u>  |                         |  |                                     | 23B. DATE SIGNED<br><u>10-28-69</u>  |  |   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>G. Patrick M.D.</u>  |                         |  |                                     | 23D. ADDRESS<br><u>ST. AGNES HOSP. WILKENS &amp; CATON AVE.</u>                                      |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                         | 24B. DATE<br><u>10-31-69</u>   |                                     | 24C. NAME OF CEMETERY OR CREMATORY<br><u>New Cathedral Cemetery</u>                                  |  | 24D. LOCATION (City, town, or county) (State)<br><u>Old Frederick Rd - Balto Md</u> |  |
| 25A. DATE REC'D BY HEALTH DPT.<br><u>NOV 3 1969</u>   |                         | 25B. NAME OF REGISTRAR<br><u>Robert E. Taylor, R.R.</u>  |                                     | 25C. FUNERAL DIRECTOR<br><u>Edw. S. MacNabb-301 Frederick Rd. 212</u>                                |  |   |  |



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

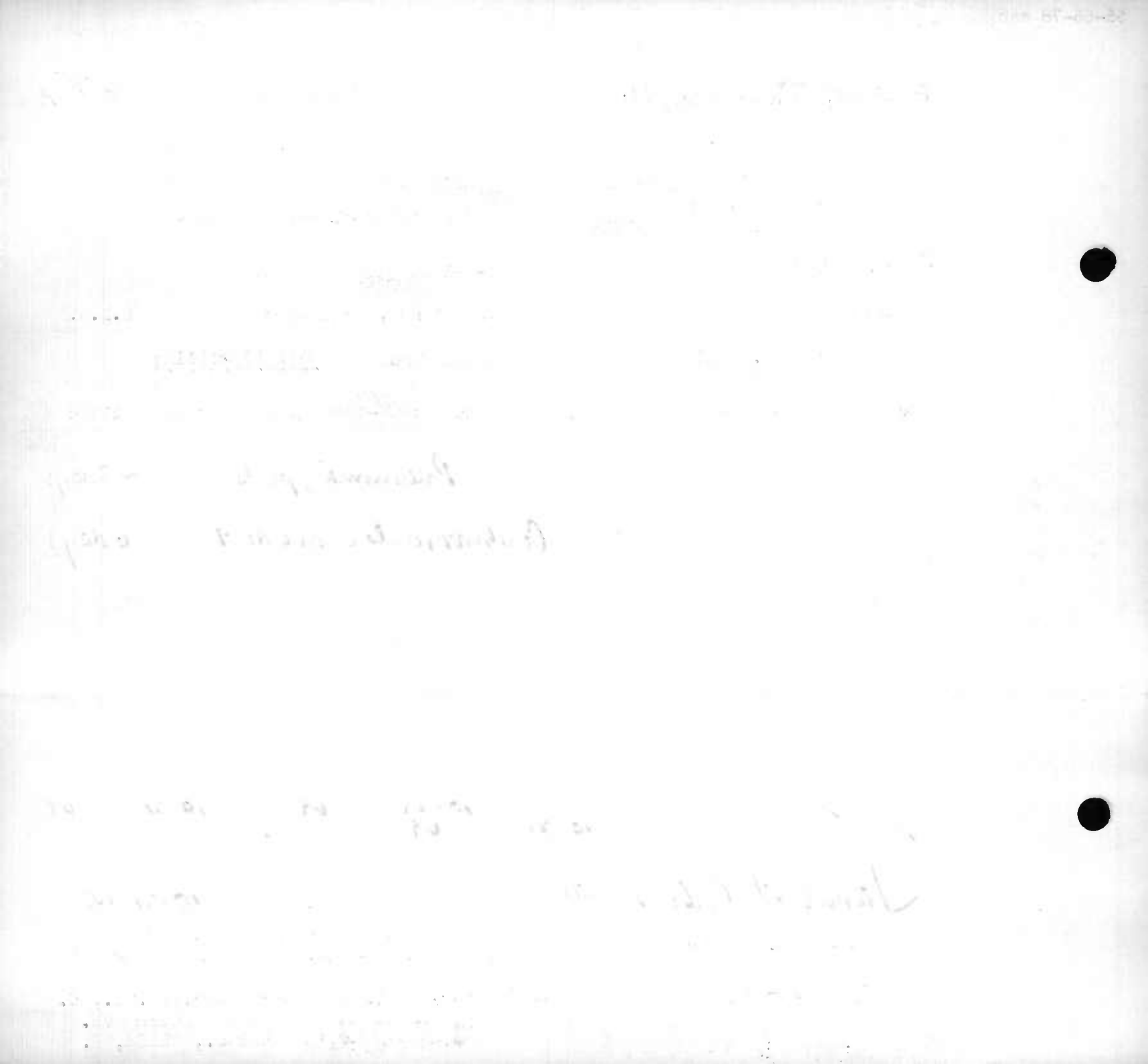
|   |                         |   |  |   |  |   |  |  |  |
|---|-------------------------|---|--|---|--|---|--|--|--|
| E-162   |                         | 69 10787  |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | X   |  | REG. NO. 69 10787                                      |  |
| BIRTH NO. <i>forgetown bur. Hosp. Wash.</i>   |                         | 1. NAME OF DECEASED<br>(Type or Print) <i>Effron, Julie</i>   |  | 2. DATE AND HOUR OF DEATH<br><i>31 Oct. 69 120 A.M.</i>   |  |   |  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                         |   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)   |  |   |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>Johns Hopkins Hospital</i>   |                         | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |  | A. STATE<br><i>Md. Montgomery</i>   |  | B. COUNTY<br><i>6500</i>  |  |  |  |
|   |                         |   |  | C. CITY OR TOWN<br><i>Bethesda, Md.</i>   |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
|   |                         |   |  | E. STREET AND NUMBER<br><i>6365 Hallens Drive</i>   |  |   |  |  |  |
| 5. SEX<br><i>Female</i>   | 6. RACE<br><i>Caus.</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><i>7/21/65</i>  |  | 9. AGE (In years last birthday)<br><i>4</i>   |  | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                         | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)   |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA.</i>   |  |  |  |
| 13. FATHER'S NAME<br><i>Robert Effron</i>   |                         |   |  | 14. MOTHER'S MAIDEN NAME<br><i>Margo Margher.</i>   |  |   |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>NO</i>   |                         | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><i>Robert Effron</i>   |  | ADDRESS   |  |  |  |
| 18. <i>422.21</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.      |                         |   |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><i>Cardiorespiratory Arrest.</i><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |                         |   |  | <i>Severely Brain Damaged</i>   |  |   |  |  |  |
| 19A. DATE OF OPERATION<br><i>2</i>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><i>YES</i>   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |   |  |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |  |   |  |  |  |
| 22. I certify that (1) (this hospital) attended the deceased from <i>31 Oct</i> 19 <i>69</i> to <i>31 Oct</i> 19 <i>69</i> that (1) (we) last saw the deceased alive on <i>31 Oct</i> 19 <i>69</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. |                         |   |  |   |  |   |  |  |  |
| 23A. SIGNATURE<br><i>W. F. Devoe, M.D.</i>  |                         |   |  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>                               |  | 23B. DATE SIGNED<br><i>31 Oct 69</i>  |  |  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><i>William F. Devoe, M.D.</i>   |                         |   |  | 23D. ADDRESS<br><i>The Johns Hopkins Hospital</i>   |  |   |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |                         | 24B. DATE<br><i>11/2/69</i>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><i>Cedar Hill Cem.</i>  |  | 24D. LOCATION (City, town, or county) (State)<br><i>Paragum Md.</i>                           |  |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>NOV 3 1969</i>  |                         | 25B. NAME OF REGISTRAR<br><i>Robert E. Salyer, R.G.</i>   |  | 25C. FUNERAL DIRECTOR<br><i>Robert E. Salyer</i>  |  | ADDRESS<br><i>Wm S. Tucker</i>  |  |  |  |





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

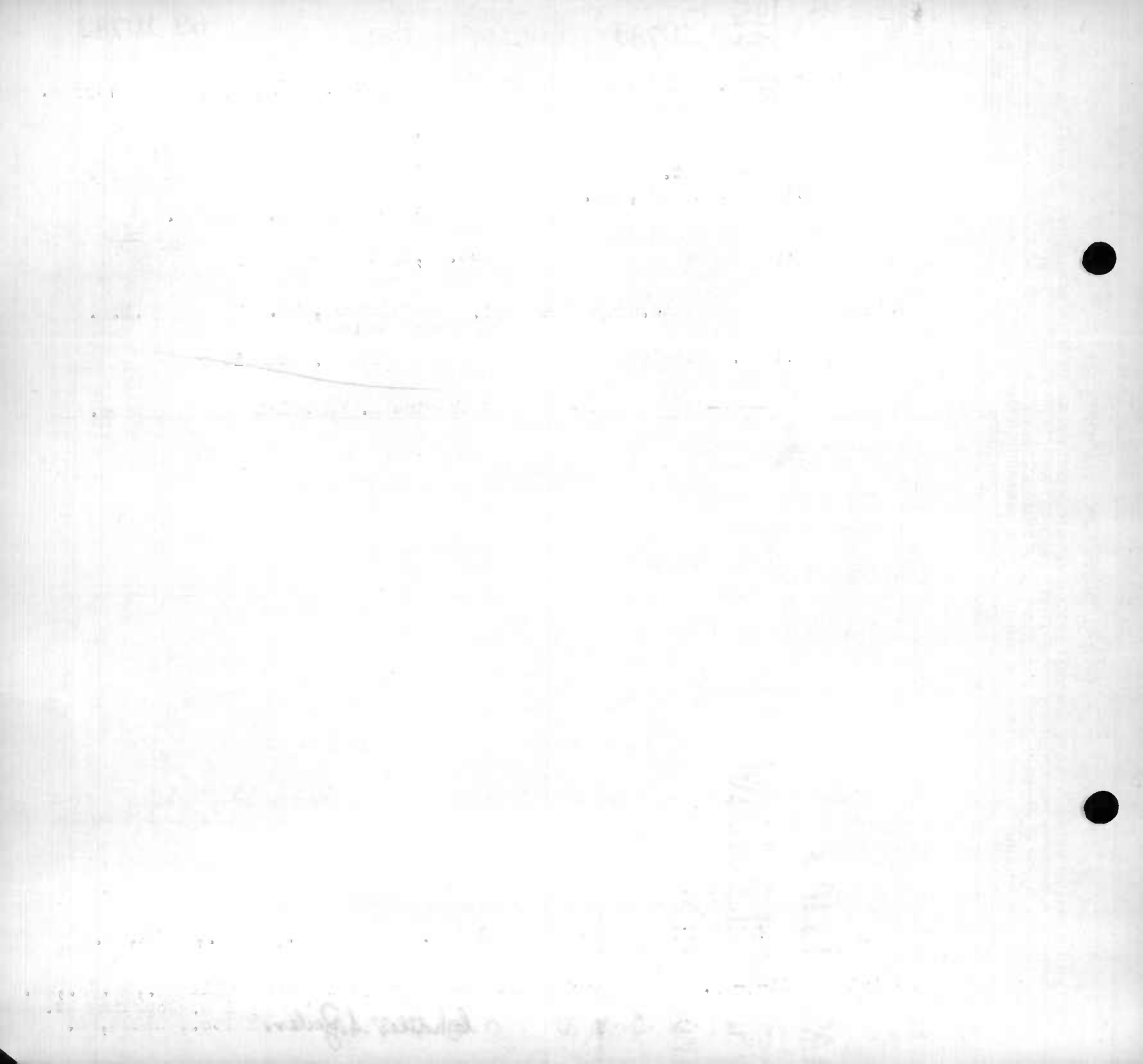
|  |                         |   |                                     |  |                        |   |                        |
|--|-------------------------|---|-------------------------------------|--|------------------------|---|------------------------|
| F-260  |                         | 69 10788  |                                     | BALTIMORE CITY HEALTH DEPARTMENT   |                        | REG. NO. 69 10788   |                        |
| BIRTH NO.  |                         |   |                                     | 2  |                        |   |                        |
| 1. NAME OF DECEASED<br>(Type or Print)<br><u>Fisher, Theresa H.</u>  |                         |   |                                     | 2. DATE AND HOUR OF DEATH<br><u>10-31-69</u> <u>6:45</u> A.M.  |                        |   |                        |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                         |   |                                     | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>Maryland</u><br>B. COUNTY <u>2605</u> |                        |   |                        |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>31</u><br><u>Baltimore City Hospitals</u><br><u>4940 Eastern Avenue</u><br><u>Baltimore, Maryland 21224</u>   |                         |   |                                     | C. CITY OR TOWN<br><u>Baltimore</u>  |                        | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                        |
|  |                         |   |                                     | E. STREET AND NUMBER<br><u>441 Elrino Street</u>   |                        | <u>21224</u>  |                        |
| 5. SEX<br><u>Female</u>  | 6. RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>1-9-1896</u> | 9. AGE (In years last birthday)<br><u>73</u>   | 10. Under 1 Yr. Months | 11. Under 24 Hrs. Days  | 12. Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired</u>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>House Work</u>  |                                     | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland, Baltimore</u>  |                        | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |                        |
| 13. FATHER'S NAME<br><u>Charles A. Winterling</u>  |                         |   |                                     | 14. MOTHER'S MAIDEN NAME<br><u>Helena Maok</u> <del>Helena Winterling</del>  |                        |   |                        |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>  |                         | 16. SOCIAL SECURITY NO.<br><u>216-10-4962D</u>  |                                     | 17. INFORMANT ADDRESS<br><u>Records: BCH-4940 Eastern Avenue 21224</u>   |                        |   |                        |
| 18. <u>436.91</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><u>Pneumonia, prob</u><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>II</u><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><u>CAUSE OF DEATH</u><br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><u>Cerebrovascular accident</u><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF: |                         |   |                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>~ 3 days</u><br><u>6 days</u>   |                        |   |                        |
| MEDICAL CERTIFICATION  |                         |   |                                     |  |                        |   |                        |
| 19A. DATE OF OPERATION<br><u>10-31-69</u>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                     | 20A. AUTOPSY? (Yes or No)<br><u>NO</u>   |                        | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |                        |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)   |                                     | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)  |                        |   |                        |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX.)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                                     | 21F. HOW DID INJURY OCCUR?   |                        |   |                        |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10-25</u> 19 <u>69</u> to <u>10-31</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>10-31</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                         |   |                                     |  |                        |   |                        |
| 23A. SIGNATURE<br><u>James T. Corkins MD</u><br>DEGREE   |                         |   |                                     | 23B. DATE SIGNED<br><u>10-31-69</u>  |                        |   |                        |
| 23C. PHYSICIAN'S NAME (Type)<br><u>James T. Corkins</u><br>DEGREE  |                         |   |                                     | 23D. ADDRESS<br><u>Baltimore City Hospitals</u><br><u>4940 Eastern Avenue, Baltimore, Maryland 21224</u>                                   |                        |   |                        |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                         | 24B. DATE<br><u>11-4-69</u>   |                                     | 24C. NAME of CEMETERY or CREMATORY<br><u>Oak Lawn Cemetery</u>   |                        | 24D. LOCATION (City, town, or county) (State)<br><u>7225 Eastern Blvd., Ba. Co., Md.</u>      |                        |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 3 1969</u>   |                         | 25B. NAME OF REGISTRAR<br><u>Robert E. Fisher</u>   |                                     | 25C. FUNERAL DIRECTOR<br><u>Charles J. Fisher</u>  |                        | ADDRESS<br><u>6224 Eastern Ave. Balto., 21224, Md.</u>  |                        |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

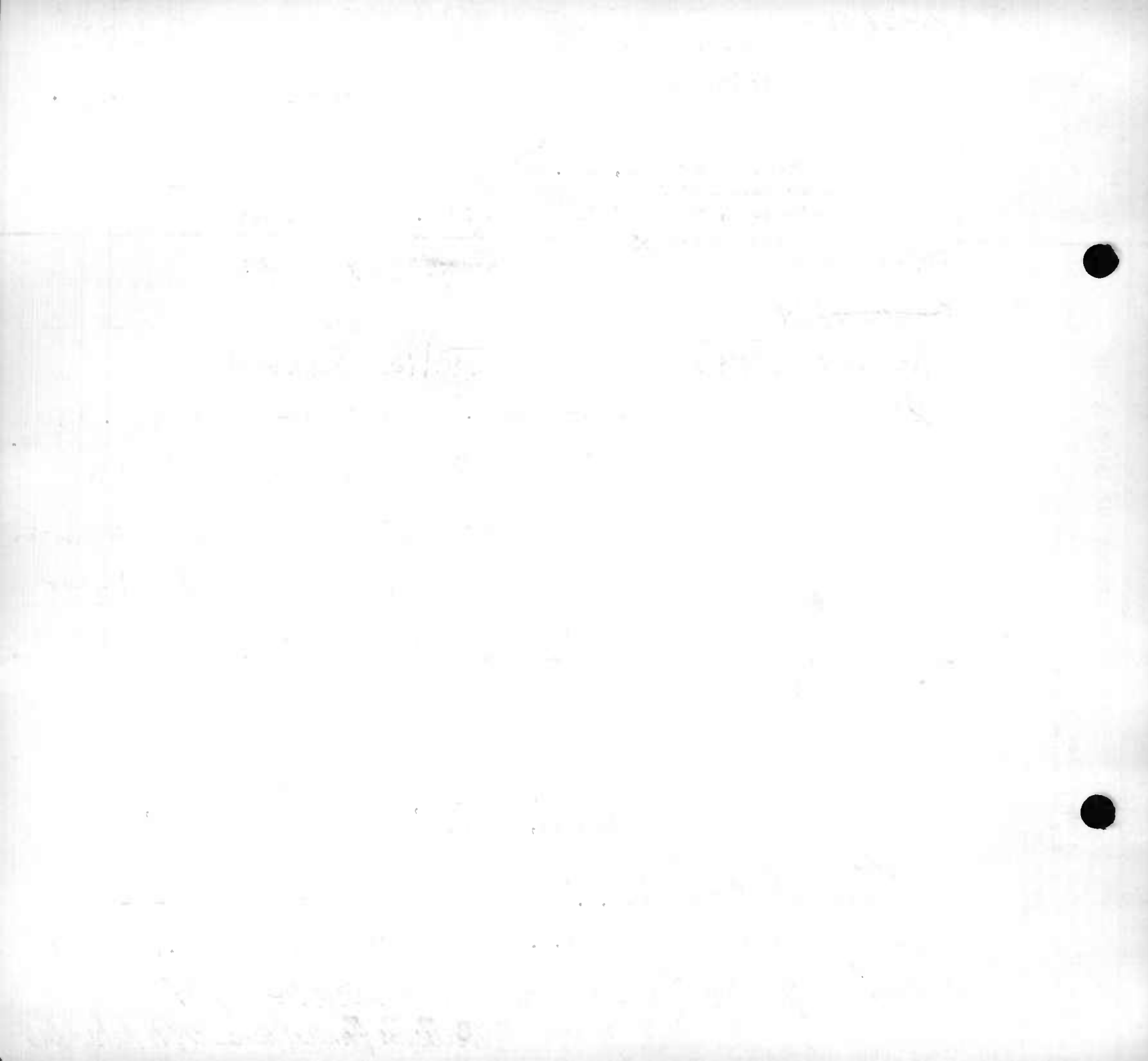
|   |  |   |  |   |  |
|---|--|---|--|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT  |  | 69 10789  |  | REG. NO. 69 10789   |  |
| BIRTH NO. <b>K-564</b>  |  | 69 10789 CERTIFICATE OF DEATH   |  |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>JOHN S. KNOERLEIN</b>   |  |   | 2. DATE AND HOUR OF DEATH<br><b>October 31, 1969 7:55 A. M.</b>  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>00 613 Rappolla St.<br/>Baltimore, 21224, Md.</b>   |  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>2605</b> |   |  |
| 5. SEX <b>Male</b>  |  | 6. RACE <b>White</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH <b>Oct. 13, 1900</b>   |  | 9. AGE (In years last birthday) <b>69</b>   |  | 10. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>  |  | 10B. KIND OF BUSINESS OR INDUSTRY <b>Balto. City Fire Dept.</b>   |  | 11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>   |  |
| 13. FATHER'S NAME <b>Lawrence F. Knoerlein</b>  |  |   | 14. MOTHER'S MAIDEN NAME <b>Anna M. Schneider</b>  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>  |  | 16. SOCIAL SECURITY NO. <b>None</b>   |  | 17. INFORMANT <b>Catherine L. Knoerlein</b> ADDRESS <b>Same.</b>  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>185X I METASTATIC CARCINOMA</b><br><b>OF PROSTATE</b>   |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>OF PROSTATE</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 YRS</b>  |  |
| II  |  |   |  |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |   |  |   |  |
| 19A. DATE OF OPERATION <b>MAY 1965</b>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CARCINOMA OF PROSTATE</b>   |  | 20A. AUTOPSY? (Yes or No) <b>NO</b>   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)   |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                       |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>NOV. 16 1962</b> to <b>OCT 31 1969</b> , that (I) (we) lost saw the deceased alive on <b>OCT. 14 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death. |  |   |  |   |  |
| 23A. SIGNATURE <b>Joseph Miceli M.D.</b>  |  |   |  | 23B. DATE SIGNED <b>11/1/69</b>   |  |
| 23C. PHYSICIAN'S NAME (Type) <b>JOSEPH MICELI</b>   |  | 23D. ADDRESS <b>M.D. 108 S. Taylor Ave., Balto., 21221, Md.</b>   |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 24B. DATE <b>11-4-69.</b>   |  | 24C. NAME of CEMETERY or CREMATORY <b>Sacred Heart Cemetery</b>   |  |
| 24D. LOCATION (City, town, or county) (State) <b>7401 German Hill Rd., Ba. Co., Md.</b>   |  | 25A. DATE REC'D BY HEALTH DEPT. <b>NOV 3 1969</b>   |  |   |  |
| 25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>  |  | 25C. FUNERAL DIRECTOR <b>901 S. Conkling St. Balto., 21224, Md.</b>   |  |   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

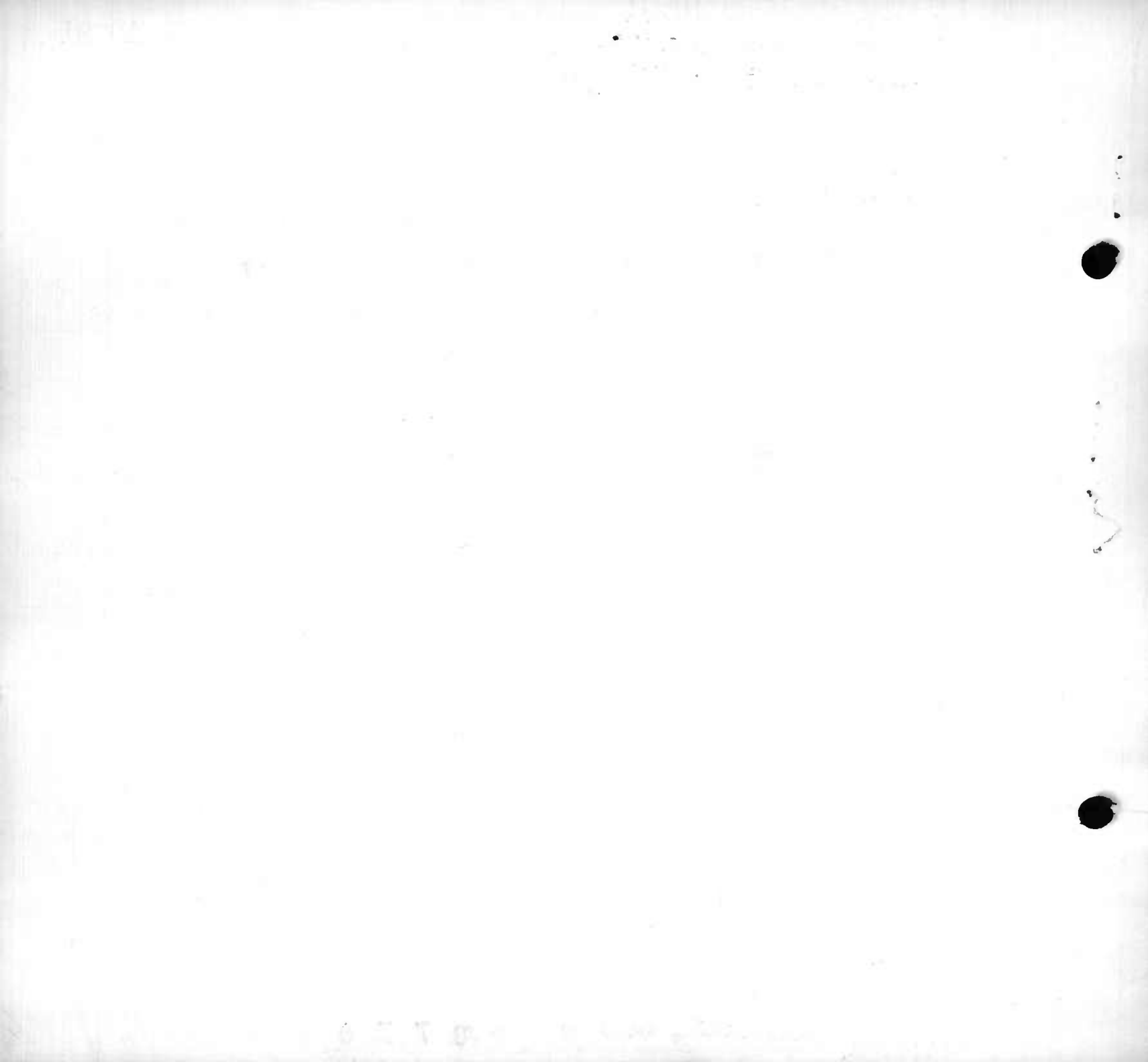
| BALTIMORE CITY HEALTH DEPARTMENT  |                                |   |  | REG. NO. <b>69 10790</b>  |  |
|---|--------------------------------|---|--|---|--|
| <b>BIRTH NO.</b><br><b>1. NAME OF DECEASED</b><br>(Type or Print) <span style="float: right;"><b>Eva Bowser</b></span>  |                                | <b>69 10790 CERTIFICATE OF DEATH</b>  |  |   |  |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><br><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Provident Hospital, Inc.</b><br><b>1514 Division Street</b><br><b>Baltimore, Maryland 21217</b>   |                                | <b>2. DATE AND HOUR OF DEATH</b><br><div style="display: flex; justify-content: space-between;"> <span><b>10-29-69</b></span> <span><b>4:50 p. m.</b></span> </div> <b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)<br><b>A. STATE</b> <b>Maryland</b><br><b>B. COUNTY</b> <b>1802</b><br><b>C. CITY OR TOWN</b> <b>Baltimore</b><br><b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br><b>E. STREET AND NUMBER</b><br><b>1025 W. Fayette Street</b> |  |   |  |
| <b>5. SEX</b><br><b>Female</b>  | <b>6. RACE</b><br><b>Negro</b> | <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>   |  | <b>8. DATE OF BIRTH</b><br><b>June 24, 1890</b>   | <b>9. AGE</b> (In years last birthday) <b>79</b> |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Unemployed H.W.</b>  |                                | <b>10B. KIND OF BUSINESS OR INDUSTRY</b>  |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>Va.</b>                                  | <b>12. CITIZEN OF WHAT COUNTRY?</b>              |
| <b>13. FATHER'S NAME</b><br><b>Reuben Jones</b>   |                                | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Julia Johnson</b>   |  |   |  |
| <b>15. Was Deceased Ever in U. S. Armed Forces?</b><br>(Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                                | <b>16. SOCIAL SECURITY NO.</b><br><b>218-10-7804A</b>   |  | <b>17. INFORMANT</b> <b>Mr. Albert Simmons- Friend</b> <b>1031 W. Fayette</b><br><b>ADDRESS</b> |  |
| <b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   |                                |   |  |   |  |
| <b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                                |   |  |   |  |
| <b>II</b><br><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>  |                                |   |  |   |  |
| <b>19A. DATE OF OPERATION</b><br><b>March 1969</b>  |                                | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b><br><b>Carcinoma, anus</b>   |  | <b>20A. AUTOPSY?</b> (Yes or No)<br><b>No</b>   |  |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)<br><b>HO</b>   |                                | <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)                 |  |
| <b>21D. TIME OF INJURY</b> (APPROX.)<br>(Month) (Day) (Year) (Hour)   |                                | <b>21E. INJURY OCCURRED</b><br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | <b>21F. HOW DID INJURY OCCUR?</b>   |  |
| <b>22. I certify that (I) (this hospital) attended the deceased from <u>October 27, 1969</u> to <u>October 29, 1969</u> that (I) (we) last saw the deceased alive on <u>October 29, 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b> |                                |   |  |   |  |
| <b>23A. SIGNATURE</b><br><b>Edward O. Hunt, M.D.</b>  |                                |   |  | <b>23B. DATE SIGNED</b><br><b>10-30-69</b>  |  |
| <b>23C. PHYSICIAN'S NAME</b> (Type)<br><b>Edward O. Hunt, M.D.</b>  |                                | <b>23D. ADDRESS</b><br><b>1514 Division Street Balto., Maryland</b>   |  |   |  |
| <b>24A. BURIAL CREMATION, REMOVAL (Specify)</b><br><b>Burial</b>  |                                | <b>24B. DATE</b><br><b>11/19/69</b>   |  | <b>24C. NAME OF CEMETERY OR CREMATORY</b><br><b>Carver Memorial Pk. Lorraine Md.</b>            |  |
| <b>24D. LOCATION</b> (City, town, or county) (State)<br><b>Baltimore Md.</b>  |                                | <b>25. FUNERAL DIRECTOR</b> <b>3997 Schowder</b>  |  |   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| W-300   |                   | 69 10791  |                             | BALTIMORE CITY HEALTH DEPARTMENT   |                              | REG. NO. 69 10791   |  |
|---|-------------------|---|-----------------------------|--|------------------------------|---|--|
| BIRTH NO. <del>XXXXXX</del> <del>XXXXXX</del> <del>XXXXXX</del> <del>XXXXXX</del>   |                   |   |                             | CERTIFICATE OF DEATH   |                              |   |  |
| 1. NAME OF DECEASED<br>(Type of Print) <del>FRANKLIN S. SCOTT</del> Dora S. Ethel White   |                   |   |                             | 2. DATE AND HOUR OF DEATH<br>11/1/69 12:30 a.m.  |                              |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>66 FRANKLIN SQUARE Hospital   |                   |   |                             | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE BALTIMORE MARYLAND USA 1901  |                              |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br>66 FRANKLIN SQUARE Hospital  |                   |   |                             | C. CITY OR TOWN<br>BALTIMORE   |                              | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
|   |                   |   |                             | E. STREET AND NUMBER<br>328 N. STRICKER ST.  |                              |   |  |
| 5. SEX<br>FEMALE  | 6. RACE<br>COLOUR | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>7/23/22 | 9. AGE (In years last birthday)<br>47  | 10. Under 1 Tr. Months; Days | 11. Under 24 Hrs. Hours; Min.   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Unemployed -   |                   |   |                             | 10B. KIND OF BUSINESS OR INDUSTRY<br>-   |                              | 11. BIRTHPLACE (State or foreign country)<br>BALTIMORE, MARYLAND                              |  |
| 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |                   |   |                             |  |                              |   |  |
| 13. FATHER'S NAME<br>EDWARD SCOTT   |                   |   |                             | 14. MOTHER'S MAIDEN NAME<br>ETHEL DOWNEY   |                              |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO -  |                   |   |                             | 16. SOCIAL SECURITY NO.<br>212-14-9443   |                              | 17. INFORMANT<br>Mrs. Beverly Levers  |  |
| 18. CAUSE OF DEATH<br>250.91<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br>19A. DATE OF OPERATION<br>10/30/69<br>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>19C. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>RT MASTOID AREA<br>20A. AUTOPSY? (Yes or No)<br>YES<br>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>20C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>328 STRICKER ST.<br>20D. HOW DID INJURY OCCUR?<br>FELL DOWN FROM 4th STEP<br>21. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> |                   |   |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 days<br>10 years<br>DIABETES MELLITUS, INSIPIDUS   |                              |   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br>21B. TIME OF INJURY (Approx.)<br>10/30/69 8:00am   |                   |   |                             | 21C. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>RT MASTOID AREA<br>21D. HOW DID INJURY OCCUR?<br>FELL DOWN FROM 4th STEP |                              |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from 10/30 1969 to 11/1 1969 that (I) (we) last saw the deceased alive on 11/1/1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                   |   |                             |  |                              |   |  |
| 23A. SIGNATURE<br>A. Chittchang   |                   |   |                             | 23B. DATE SIGNED<br>11/1/69  |                              | 23C. PHYSICIAN'S NAME (Type)<br>(A. CHITTCHANG)   |  |
| 23D. ADDRESS<br>FRANKLIN SQUARE HOSPITAL  |                   |   |                             |  |                              |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |                   | 24B. DATE<br>11/5/69  |                             | 24C. NAME of CEMETERY or CREMATORY<br>Baltimore Nat'l Cem.   |                              | 24D. LOCATION (City, town, or county) (State)<br>Baltimore Maryland                           |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 3 1969   |                   | 25B. NAME OF REGISTRAR<br>Robert E. Taylor  |                             | 25C. FUNERAL DIRECTOR<br>Morton F. O'Connell   |                              | 25D. ADDRESS<br>1701 Laurens St.  |  |





69 10792

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 10792

BIRTH NO.

|   |  |   |  |
|---|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>MOSES BLENCH (Blanche)</b>  |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> M.       |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>00 30 N. Smallwood Street</b>  |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>October 28, 1969 1:12 P.M.</b>                                   |  |
| 6. SEX<br><b>Male</b>   |  | 7. RACE<br><b>Negro</b>   |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | C. CITY OR TOWN<br><b>Baltimore</b>   |  |
| 9. DATE OF BIRTH<br><b>6-30-09</b>  |  | 10. AGE (In years lost birthday)<br><b>60</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Emporia, Virginia</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Disable</b>   |  | 14B. KIND OF BUSINESS OR INDUSTRY   |  |
| 15. MOTHER'S MAIDEN NAME<br><b>Lucy Dennis</b>  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No.</b> |  |
| 17. SOCIAL SECURITY NO.   |  | 18. INFORMANT<br><b>Mr. Edward Blanche</b>  |  |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Arteriosclerotic Cardiovascular Disease</b>  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |  | (B) DUE TO, OR AS A CONSEQUENCE OF:   |  |
| 20A. DATE OF OPERATION  |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                              |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?  |  | 22D. TIME (Month) (Day) (Year) (Hour)   |  |
| 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 22F. HOW DID INJURY OCCUR?  |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |
| ACTUAL SIGNATURE<br><b>Ronald N. Kornblum, M.D.</b>   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |
| EXAMINER'S NAME (Type)  |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 24B. DATE<br><b>11-1-69</b>   |  |
| 24C. NAME of CEMETERY or CREMATORY<br><b>Mt. Auburn Cemetery</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 3 1969</b>  |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>   |  |
| 25C. FUNERAL DIRECTOR<br><b>MORTON &amp; DYETT F.H.</b>   |  | ADDRESS<br><b>1701 Laurens St.</b>  |  |

WALLEY FOLIO

254 PAGES CONTAIN

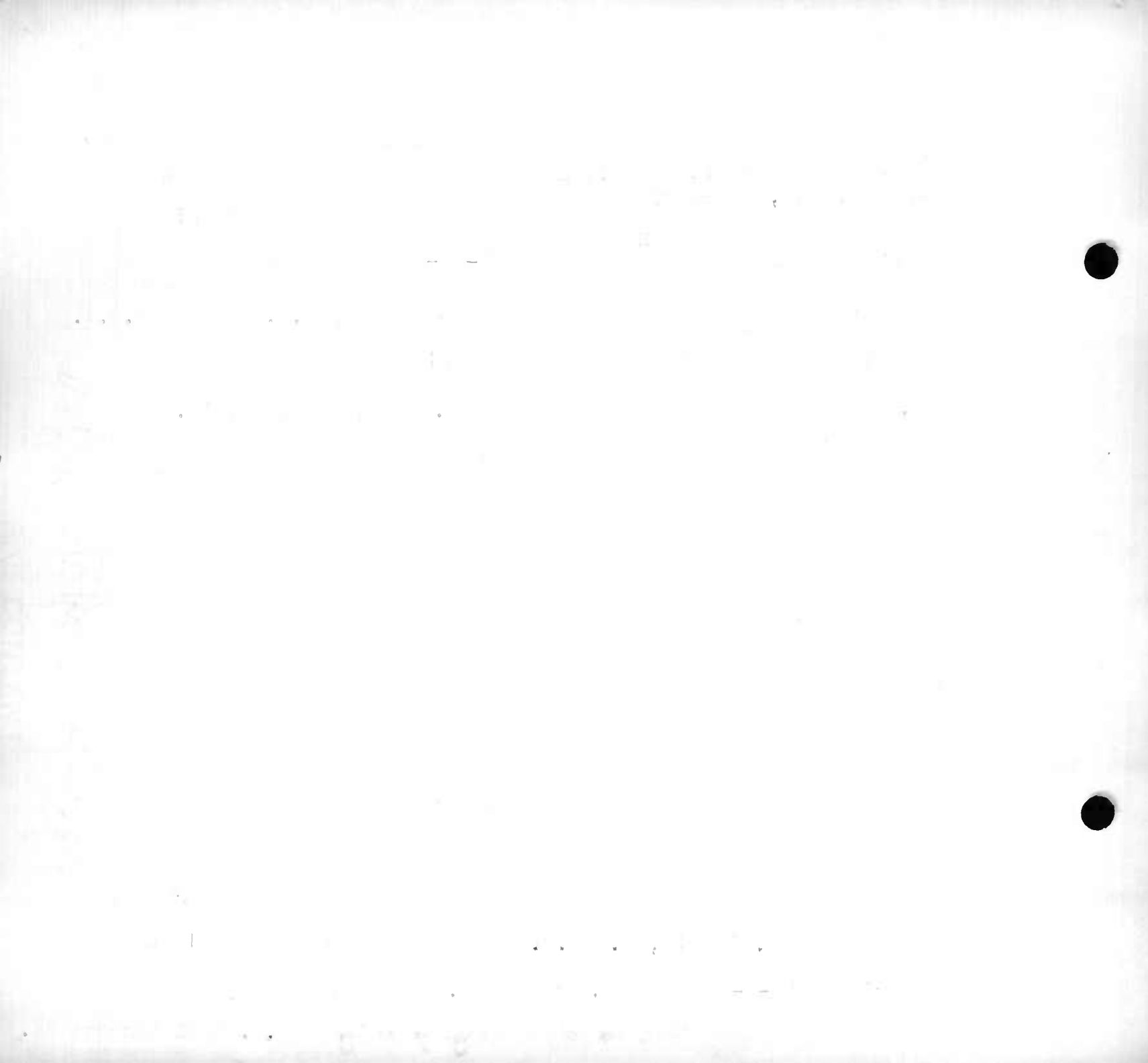
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7770

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |                         |   |   | REG. NO. <b>69 10793</b>  |   |
|--|-------------------------|---|---|---|---|
| BIRTH NO. <b>B-420</b>   |                         |   |   | 69 10793  |   |
| CERTIFICATE OF DEATH   |                         |   |   |   |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>@LOYCE MAE BLACK</b>   |                         |   | 2. DATE AND HOUR OF DEATH<br><b>11/1/69</b> <b>8<sup>30</sup> A</b> M.  |   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                         |   | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>301</b>                                   |   |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>THE JOHNS HOPKINS HOSPITAL</b><br><b>33 BALTIMORE, MD 21205</b>   |                         |   | C. CITY OR TOWN<br><b>BALTIMORE</b>   |   | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|  |                         |   | E. STREET AND NUMBER<br><b>302 SOUTH EDEN STREET</b>  |   |   |
| 5. SEX<br><b>FEMALE</b>  | 6. RACE<br><b>NEGRO</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>7-30-35</b>  | 9. AGE (In years last birthday)<br><b>34</b>                                | If Under 1 Yr. Months: Days: Hours: Min.  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Statesville, N.C.</b>       |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                         |   |   |   |   |
| 13. FATHER'S NAME<br><b>WILLIE Ray Robertson</b>   |                         |   | 14. MOTHER'S MAIDEN NAME<br><b>NINA SCALES</b>  |   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No.</b>   |                         | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS<br><b>Mr. Benjamin Black, Sr. Same</b>                |   |
| 18. <b>174 X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |                         |   | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>METASTATIC BREAST CARCINOMA 5 years</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____ |   |   |
| 19A. DATE OF OPERATION   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)<br><b>No</b>                                      |   |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location) |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |   | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10/22/69</b> to <b>11/1/69</b> that (I) (we) last saw the deceased alive on <b>11/1/69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                         |   |   |   |   |
| 23A. SIGNATURE<br><b>Clarence W. Gehris, Jr. M.D.</b>  |                         |   |   | 23B. DATE SIGNED<br><b>11/1/69</b>  |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>CLARENCE W. GEHRIS, JR. M.D.</b>  |                         |   |   | 23D. ADDRESS<br><b>THE JOHNS HOPKINS HOSPITAL</b>                           |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 24B. DATE<br><b>11-6-69</b>   |   | 24C. NAME OF CEMETERY or CREMATORY<br><b>Balto. Nat'l Cem.</b>              |   |
| 24D. LOCATION<br><b>Baltimore, Maryland</b>  |                         |   |   |   |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 3 1969</b>   |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>   |   | 25C. FUNERAL DIRECTOR<br><b>MORTON &amp; DYETT F.H.</b>                     |   |
|  |                         |   |   | ADDRESS<br><b>1701 Laurens St.</b>  |   |



H-450

D-120

69 10794

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 10794

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

SAMUEL DAVIS (Hillian)

2. DATE  
OF DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

10

30

69

11:40 p.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

Oct.

30,

1969

11:40 p.m.

5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

Maryland

1506

6. SEX

7. RACE

B. MARRIED ☐ NEVER MARRIED ☒

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Male

Negro

WIDOWED ☐DIVORCED ☐

Balto.

YES ☒NO ☐

9. DATE OF BIRTH

10. AGE (In years  
last birthday)If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

9-30-1907

62

E. STREET AND NUMBER

2911 Walbrook Ave.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Chesterfield, S.C.

U.S.A.

Unk.

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Retired

Tessie Hillian

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give year or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Yes

6/20/42 5/1/43

219-22-3710

Rev. J.R. Hillian

2911 Walbrook Ave.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Cirrhosis of the liver  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒

DATE SIGNED

EXAMINER'S  
NAME (Type)

Isidore Mihalakis, M.D.

ASSOCIATE MEDICAL EXAMINER ☐ 10/31/6924A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

11-5-69

Baltimore Nat'l Cem.

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

NOV 3

1969

Robert E. Farber, M.D.

MORTON &amp; DYETT F.H. 1701 Laurens St.

20X01 20

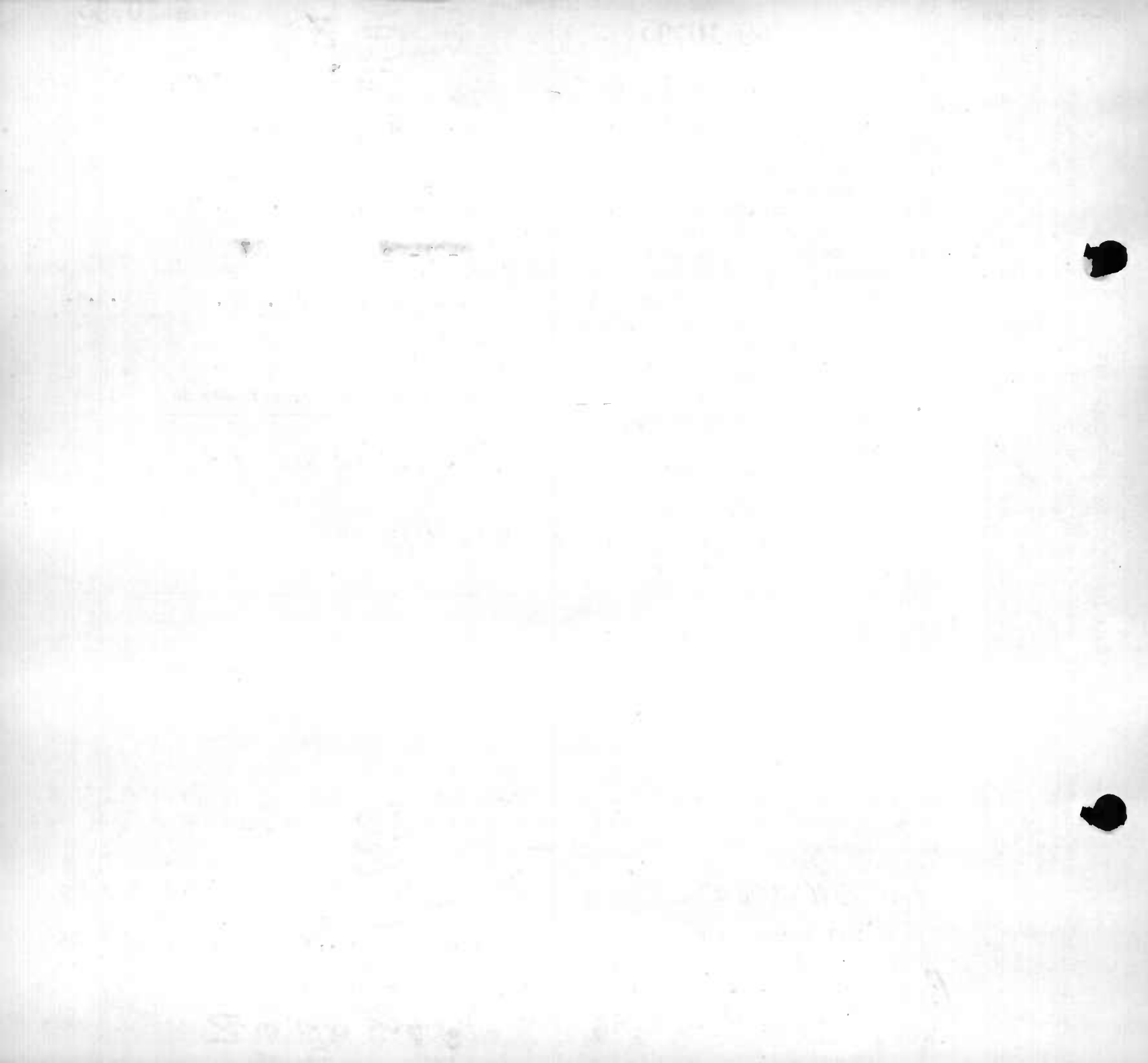
1901 20

WALLACE HOLMES

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                  |  |                             |  |                            |  |  |
|---|------------------|--|-----------------------------|--|----------------------------|--|--|
| W-356   |                  | 69 10795   |                             | BALTIMORE CITY HEALTH DEPARTMENT   |                            | REG. NO. 69 10795  |  |
| BIRTH NO.   |                  | 1. NAME OF DECEASED<br>(Type or Print) Wesley H. Whitmore  |                             | 2. DATE AND HOUR OF DEATH<br>October 30, 1969 10:10 a.m.                                 |                            |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>A. STATE Maryland B. COUNTY Baltimore   |                             | C. CITY OR TOWN Balto.   |                            | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>31 Baltimore City Hospitals<br>4940 Eastern Avenue<br>Baltimore, Maryland 21224   |                  | E. STREET AND NUMBER<br>130 Honeysuckle Ct. 21222  |                             |  |                            |  |  |
| 5. SEX<br>Male  | 6. RACE<br>Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                      | 8. DATE OF BIRTH<br>7-21-52 | 9. AGE (In years last birthday) 17   | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Student  |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>School  |                             | 11. BIRTHPLACE (State or foreign country)<br>Maryland, Balto. Co.                        |                            | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 13. FATHER'S NAME<br>Leroy Whitmore   |                  | 14. MOTHER'S MAIDEN NAME<br>Thelma Randall   |                             |  |                            |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No.   |                  | 16. SOCIAL SECURITY NO.<br>-0-   |                             | 17. INFORMANT<br>Records: BCH-4940 Eastern Avenue  |                            | ADDRESS<br>21224   |  |
| 18. 74691<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. |                  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>Congenital heart disease - 17yrs.<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) Polycythemia<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C)..... |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |                            |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                  |  |                             |  |                            |  |  |
| 19A. DATE OF OPERATION<br>2   |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                             | 20A. AUTOPSY? (Yes or No)<br>yes   |                            | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>YES                |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                             | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                 |                            |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                             | 21F. HOW DID INJURY OCCUR?   |                            |  |  |
| 22. I certify that (s) (this hospital) attended the deceased from Oct. 30 1969 to Oct. 30 1969, that (s) (we) lost saw the deceased alive on Oct. 30 19 69 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (s) (We) (did) (did not) view the body after death.                                      |                  |  |                             |  |                            |  |  |
| 23A. SIGNATURE<br>Carl Winterstein  |                  | 23B. PHYSICIAN'S NAME (Type)<br>Carl Winterstein   |                             | 23C. ADDRESS<br>Baltimore City Hospitals<br>4940 Eastern Ave., Baltimore, Maryland 21224 |                            | 23D. DATE SIGNED<br>10/30/69   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |                  | 24B. DATE<br>11/3/69   |                             | 24C. NAME OF CEMETERY or CREMATORY<br>Garden of Eternal Hope                             |                            | 24D. LOCATION (City, town, or county) (State)<br>Finksburg, Md.                            |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 3 1969   |                  | 25B. NAME OF REGISTRAR<br>Robert E. Taylor M.D.  |                             | 25C. FUNERAL DIRECTOR<br>Mortens Dyett F.H.  |                            | ADDRESS<br>1701 Laurens St.  |  |





**B-655 69 10796 BALTIMORE CITY HEALTH DEPARTMENT**

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** REG. NO. **69 10796**

**CERTIFICATE AMENDED**

**1. NAME OF DECEASED** (Type or Print) **BETTY BRYNUM (Bynum)**

**2. DATE OF DEATH** Known ☐ Estimated ☐ Month Day Year Hour  
**November 1, 1969 11:00 P.**

**3. DATE PRONOUNCED DEAD** Month Day Year Hour  
**November 1, 1969 11:00 P.**

**4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD** (In home, hospital, institution, or street)  
**UNIVERSITY HOSPITAL**

**5. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission)  
**A. STATE Maryland B. COUNTY 1207**

**6. SEX Female 7. RACE Negro 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒**

**9. DATE OF BIRTH 3-1-1934 10. AGE (In years lost birthday) 35 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.**

**13. FATHER'S NAME Gassaway Parker 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Anchor Hocking 15. MOTHER'S MAIDEN NAME Pearl Randall**

**16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No. 17. SOCIAL SECURITY NO. 216-30-5608 18. INFORMANT Mrs. Pearl Parker 2536 W. Mosher St.**

**19. CAUSE OF DEATH**  
**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** Peritoneal Hemorrhage complicating Septic Abortion  
**(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:**  
**(B) DUE TO, OR AS A CONSEQUENCE OF:**  
**(C) DUE TO, OR AS A CONSEQUENCE OF:**

**II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).**

**20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) yes**

**22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Unk. 22C. WHERE DID INJURY OCCUR? Unk. 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) Unk. 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 22F. HOW DID INJURY OCCUR? Unk. Criminal Abortion**

**23. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☒**  
**ACTUAL SIGNATURE: [Signature] M.D. 24. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 11-6-69 24C. NAME OF CEMETERY or CREMATORY Baltimore Nat'l Cem. 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland**  
**25A. DATE REC'D BY HEALTH DEPT. NOV 3 1969 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. 25C. FUNERAL DIRECTOR ADDRESS MORTON & DYETT F.H. 1701 Laurens St.**

Letter dated 12/4/69 from Dr. Ronald N. Kornblum

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                                 |   |   |  |   |
|---|---------------------------------|---|---|--|---|
| <p><b>P-626</b></p> <p style="font-size: 24pt; font-weight: bold;">69 10797</p>   |                                 | <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="font-size: 24pt; font-weight: bold;">CERTIFICATE OF DEATH</p>   |   | <p>REG. NO. <b>69 10797</b></p>  |   |
| <p>BIRTH NO.</p>  |                                 | <p>1. NAME OF DECEASED<br/>(Type or Print)<br/><b>(Mable) Mabel Parker (Parker)</b></p>   |   | <p>2. DATE AND HOUR OF DEATH<br/><b>10-30-69 3:15 P.M.</b></p>   |   |
| <p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>   |                                 | <p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br/>A. STATE <b>Md</b> B. COUNTY <b>1547</b></p>   |   | <p>C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> |   |
| <p>FULL NAME OF HOSPITAL OR INSTITUTION<br/><b>37 Mercy Hospital</b></p>  |                                 | <p>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p>   |   | <p>E. STREET AND NUMBER<br/><b>2321 N. Longwood St</b></p>   |   |
| <p>5. SEX<br/><b>F</b></p>  | <p>6. RACE<br/><b>Negro</b></p> | <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br/>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>   | <p>8. DATE OF BIRTH<br/><b>1-9-05</b></p> | <p>9. AGE (In years last birthday)<br/><b>64</b></p>   | <p>If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.</p> |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br/><b>Housewife</b></p>   |                                 | <p>10B. KIND OF BUSINESS OR INDUSTRY<br/><b>Home</b></p>  |   | <p>11. BIRTHPLACE (State or foreign country)<br/><b>Maryland, Baltimore</b></p>  |   |
| <p>12. CITIZEN OF WHAT COUNTRY?<br/><b>U.S.A.</b></p>   |                                 | <p>13. FATHER'S NAME<br/><b>Joseph Hicks</b></p>  |   | <p>14. MOTHER'S MAIDEN NAME<br/><b>Rose Hardy</b></p>  |   |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br/><b>No.</b></p>  |                                 | <p>16. SOCIAL SECURITY NO.</p>  |   | <p>17. INFORMANT<br/><b>Mrs. Edith Dennis 2321 Longwood St.</b></p>  |   |
| <p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br/>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> |                                 | <p>CAUSE OF DEATH</p>   |   | <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>  |   |
| <p>ANTECEDENT CAUSES<br/>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>  |                                 | <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br/><b>Cerebral edema</b></p>  |   |  |   |
|   |                                 | <p>(B) <b>Renal failure</b><br/>DUE TO, OR AS A CONSEQUENCE OF:</p>   |   |  |   |
|   |                                 | <p>(C)</p>  |   |  |   |
| <p>II<br/>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>  |                                 |   |   |  |   |
| <p>19A. DATE OF OPERATION<br/><b>2</b></p>  |                                 | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>   |   | <p>20A. AUTOPSY? (Yes or No)<br/><b>YES</b></p>  |   |
| <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b></p>  |                                 | <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>  |   | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>                                    |   |
| <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>   |                                 | <p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>  |   | <p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>                      |   |
| <p>21F. HOW DID INJURY OCCUR?</p>   |                                 | <p>22. I certify that (I) (this hospital) attended the deceased from <b>10-26-1969</b> to <b>10-30-1969</b> that (I) (we) last saw the deceased alive on <b>19</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p> |   |  |   |
| <p>23A. SIGNATURE<br/><b>M. A. Jozayry</b></p>  |                                 | <p>23B. DATE SIGNED</p>   |   | <p>23C. PHYSICIAN'S NAME (Type)<br/><b>M. A. Jozayry</b></p>   |   |
| <p>23D. ADDRESS<br/><b>Mercy Hosp.</b></p>  |                                 | <p>24A. BURIAL CREMATION, REMOVAL (Specify)<br/><b>Burial</b></p>   |   |  |   |
| <p>24B. DATE<br/><b>11-3-69</b></p>   |                                 | <p>24C. NAME OF CEMETERY OR CREMATORY<br/><b>Arbutus Memorial Park</b></p>  |   | <p>24D. LOCATION (City, town, or county) (State)<br/><b>Baltimore, Maryland</b></p>  |   |
| <p>25A. DATE RECEIVED BY HEALTH DEPT.<br/><b>NOV 5 1969</b></p>   |                                 | <p>25B. NAME OF REGISTRAR<br/><b>Robert E. Bailey, R.D.</b></p>   |   | <p>25C. FUNERAL DIRECTOR<br/><b>MORTON &amp; DEWITT F.H.</b></p>   |   |
| <p>25D. ADDRESS<br/><b>1701 Laurens St.</b></p>   |                                 |   |   |  |   |

11/13/69 - Correction form from funeral director.

*Albe*

S-351

69 10798 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 10798

BIRTH NO.

|   |  |  |  |
|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>THOMAS R. STANFIELD</b>   |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> Month Day Year |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>BALTO. CITY HOSPITAL (DOA)</b>                         |  | 3. DATE PRONOUNCED DEAD<br>November 1, 1969 7:30 A. M.   |  |
| 6. SEX<br>Male  |  | 7. RACE<br>Negro   |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | C. CITY OR TOWN<br>Baltimore   |  |
| 9. DATE OF BIRTH<br>8-1-1917  |  | 10. AGE (in years last birthday)<br>52   |  |
| 11. BIRTHPLACE (State or foreign country)<br>Caswell Co., N.C.  |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Maintenance Man  |  | 14B. KIND OF BUSINESS OR INDUSTRY<br>Diamond Press   |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>No.  |  | 17. SOCIAL SECURITY NO.  |  |
| 18. INFORMANT<br>Miss Jean Stanfield  |  | ADDRESS<br>1203 N. Durham  |  |

|   |  |   |  |  |
|---|--|---|--|--|
| MEDICAL CERTIFICATION   | 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Arteriosclerotic Cardiovascular Disease</b> |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|   | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:   |   |  |  |
|   | (B) DUE TO, OR AS A CONSEQUENCE OF:  |   |  |  |
|   | (C) DUE TO, OR AS A CONSEQUENCE OF:  |   |  |  |
|   | II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>Fracture Cervical Spine</b>   |   |  |  |
|   | 20A. DATE OF OPERATION<br>2  |   |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |
|   | 21. AUTOPSY? (Yes or No)<br>yes  |   |  |  |
|   | 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |   |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>Street                   |
|   | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br>Monument St. 92' West of Haven Street  |   |  |  |
|   | 22D. TIME (Month) (Day) (Year) (Hour) (Approx.)<br>11-1-69 7:00 A. m.  |   |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> |
| 22F. HOW DID INJURY OCCUR?<br>Driver collapsed and lost control of car  |  |   |  |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE: <i>Ronald N. Kornblum</i> M.D.<br>EXAMINER'S NAME (Type): Ronald N. Kornblum, M.D.<br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED: 11/2/69 |  |   |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |  | 24B. DATE<br>11-6-69  |  |  |
| 24C. NAME OF CEMETERY or CREMATORY<br>St. James Church Cem.   |  | 24D. LOCATION (City, town, or county) (State)<br>Caswell Co. North Carolina |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 3 1969   |  | 25B. NAME OF REGISTRAR<br>Robert E. Fisher, M.D.                            |  |  |
| 25C. FUNERAL DIRECTOR<br>MORTON & DYETT F.H.  |  | ADDRESS<br>1701 Laurens St.   |  |  |

ACADEMIC RECORD

DATE CONTINUED

UNIT 17: CHAPTER 10

UNIT 18: CHAPTER 11

UNIT 19: CHAPTER 12

UNIT 20: CHAPTER 13

UNIT 21: CHAPTER 14

UNIT 22: CHAPTER 15

UNIT 23: CHAPTER 16

UNIT 24: CHAPTER 17

UNIT 25: CHAPTER 18

UNIT 26: CHAPTER 19

UNIT 27: CHAPTER 20

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UNIT 37: CHAPTER 30

UNIT 38: CHAPTER 31

UNIT 39: CHAPTER 32

UNIT 40: CHAPTER 33

UNIT 41: CHAPTER 34

UNIT 42: CHAPTER 35

UNIT 43: CHAPTER 36

UNIT 44: CHAPTER 37

UNIT 45: CHAPTER 38

UNIT 46: CHAPTER 39

UNIT 47: CHAPTER 40

UNIT 48: CHAPTER 41

B-423

## BALTIMORE CITY HEALTH DEPARTMENT

69 10799 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 10799

BIRTH NO.

|  |                         |   |  |
|--|-------------------------|---|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>HARRY BLACKSTON</b>   |                         | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month <b>10</b> Day <b>31</b> Year <b>69</b> Hour <b>10:15 a.m.</b> |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>00 317 S. Bethel St.</b>  |                         | 3. DATE PRONOUNCED DEAD<br>Month <b>October</b> Day <b>31</b> Year <b>1969</b> Hour <b>10:15 a.m.</b>   |  |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>301</b>   |                         |   |  |
| 6. SEX<br><b>Male</b>  | 7. RACE<br><b>Negro</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>             |  |
| 9. DATE OF BIRTH<br><b>Sept. 11, 1885</b>  |                         | 10. AGE (In years lost birthday) <b>84</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Balto. Md.</b>   |                         | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>  |                         | 14B. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                         | 17. SOCIAL SECURITY NO.<br><b>220-03-6351</b>   |  |
| 18. INFORMANT<br><b>Bertha Blackston</b>   |                         | ADDRESS<br><b>3413 Fairview Ave.</b>  |  |
| 19. CAUSE OF DEATH<br><b>412.4</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Arteriosclerotic cardiovascular disease</b><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:   |                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                         |   |  |
| 20A. DATE OF OPERATION<br><b>0</b>   |                         | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                         | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?   |                         |   |  |
| 22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)  |                         | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |
| 22F. HOW DID INJURY OCCUR?   |                         |   |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Isidore Mihalakis, M.D.</b> M.D.<br>EXAMINER'S NAME (Type)<br>DATE SIGNED <b>10/31/69</b> |                         |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 24B. DATE<br><b>11-4-69</b>   |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>MT. Auburn Cem.</b>   |                         | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore Md.</b>   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 3 1969</b>   |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>   |  |
| 25C. FUNERAL DIRECTOR<br><b>Elroy G. Wilson</b>  |                         | ADDRESS<br><b>1000 B. H. T. Ave. Balto. Md.</b>   |  |



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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

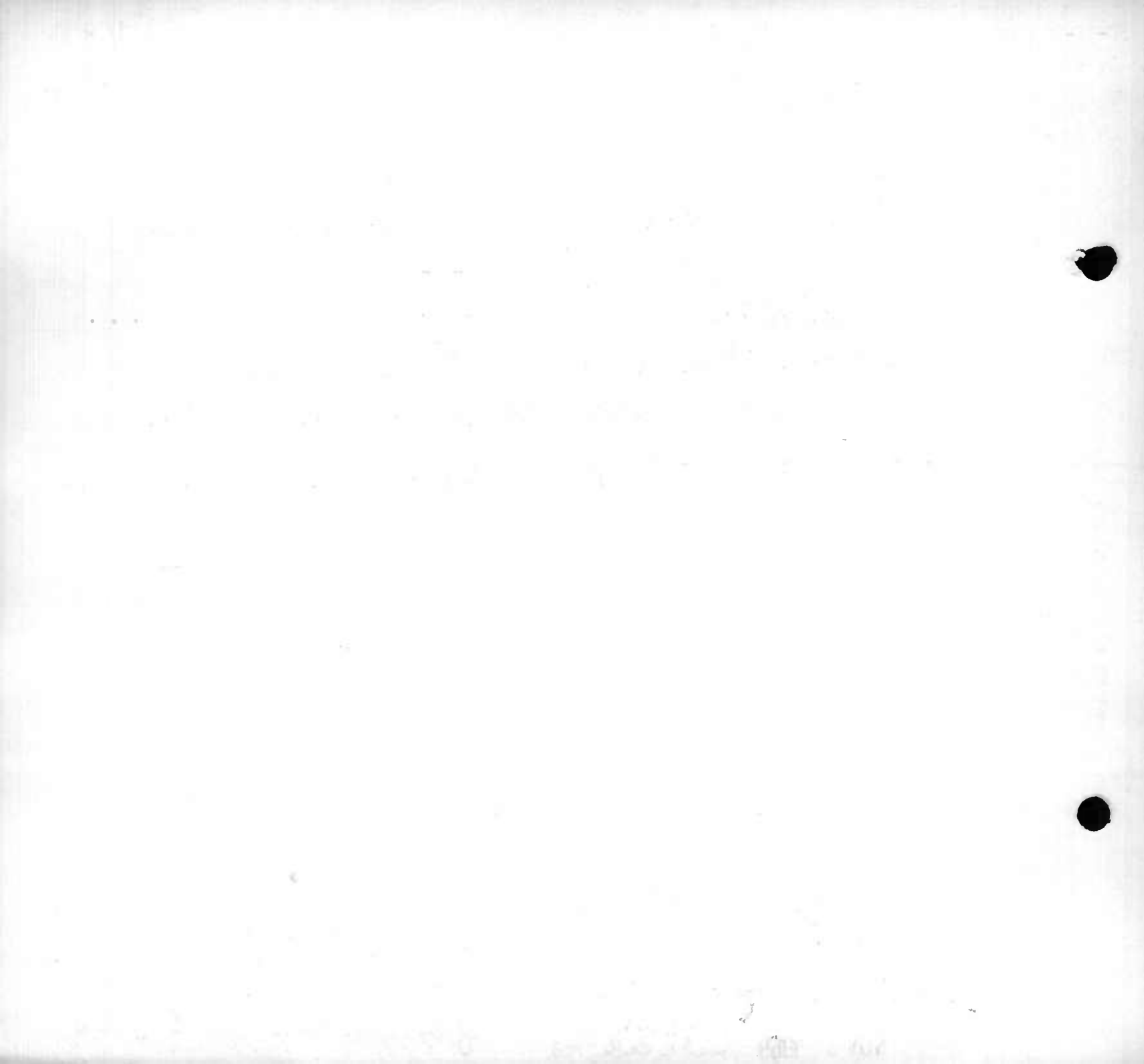
69 10800

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 10800

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| BIRTH NO.   |  | 1. NAME OF DECEASED<br>(Type or Print)<br><i>Charles Lewis</i>  |  | 2. DATE AND HOUR OF DEATH<br><i>10/28/69 7<sup>15</sup> A.M.</i>   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY <i>604</i> |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>Baltimore City Hospitals</i><br><i>4940 Eastern Avenue</i><br><i>Baltimore, Maryland 21221</i>   |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                      |  | C. CITY OR TOWN<br><i>Baltimore</i>  |  |
| 5. SEX<br><i>Male</i>   |  | 6. RACE<br><i>Negro</i>   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH<br><i>6-19-13</i>  |  | 9. AGE (In years last birthday)<br><i>56</i>   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Retired</i>   |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><i>Virginia</i>   |  |
| 13. FATHER'S NAME<br><i>Merran Pleasant</i>   |  | 14. MOTHER'S MAIDEN NAME<br><i>Bate Lewis</i>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>no</i>   |  | 16. SOCIAL SECURITY NO.<br><i>225-18-5844</i>   |  | 17. INFORMANT<br><i>BCH:Records Baltimore, Maryland 21221</i>  |  |
| 18. <i>162.1 I</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>I (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><i>II</i><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><i>bronchopneumonia</i> |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><i>Squamous Cell Ca of lung</i>                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>1 yr.</i>   |  |
| (B) DUE TO, OR AS A CONSEQUENCE OF:   |  | (C) DUE TO, OR AS A CONSEQUENCE OF:   |  |  |  |
| 19A. DATE OF OPERATION<br><i>10/27/69</i>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><i>No</i>   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>10/16/69</i> to <i>10/28/69</i> that (I) (we) lost saw the deceased alive on <i>10/27/69</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |  |   |  |  |  |
| 23A. SIGNATURE<br><i>Lynne I. Neeffe</i>  |  |   |  | 23B. DATE SIGNED<br><i>10/28/69</i>  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><i>LYNNE I. NEEFFE</i>  |  |   |  | 23D. ADDRESS<br><i>Baltimore City Hospitals</i><br><i>4940 Eastern Avenue Baltimore, Maryland 21221</i>                                |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |  | 24B. DATE<br><i>11-1-69</i>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><i>Mt Calvary Cmt</i>  |  |
| 24D. LOCATION (City, town, or county) (State)<br><i>A. A. County Md</i>   |  | 25A. DATE REC'D BY HEALTH DEPT.   |  | 25B. NAME OF REGISTRAR<br><i>Robert E. Taber, M.D.</i>   |  |
| 25C. FUNERAL DIRECTOR<br><i>Elmer W. Wilson</i>   |  | 25D. ADDRESS<br><i>1000 Brantley St</i>   |  |  |  |

NOV 3 1969



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J-520

## BALTIMORE CITY HEALTH DEPARTMENT

69 10801

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 10801

BIRTH NO.

|   |                                     |  |  |
|---|-------------------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) ISAAH JONES JR   |                                     | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> M.  |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>33 CHURCH HOME AND HOSPITAL   |                                     | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br>October 31, 1969 7:25 P.M.   |  |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland B. COUNTY 301  |                                     | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 6. SEX Male   | 7. RACE Negro                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>              |  |
| 9. DATE OF BIRTH<br>Set 12-1928   | 10. AGE (In years last birthday) 41 | 11. BIRTHPLACE (State or foreign country) Baltimore  |  |
| 12. CITIZEN OF WHAT COUNTRY? USA  |                                     | 13. FATHER'S NAME Isaac Jones Sr   |  |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                                     | 15. MOTHER'S MAIDEN NAME Maggie Galloway   |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No  |                                     | 17. SOCIAL SECURITY NO. 220-22-9665  |  |
| 18. INFORMANT Lawrence Jones Jr 1409 Camden St  |                                     | ADDRESS  |  |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>Multiple Gunshot wounds and stab wounds   |                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 20. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                                     | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:                                     |  |
| 20A. DATE OF OPERATION  |                                     | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 21. AUTOPSY? (Yes or No)<br>yes   |                                     |  |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                     | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Streets   |  |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Baltimore and Eden Streets 301   |                                     | 22D. TIME (Month) (Day) (Year) (Hour) (Approx.) Oct. 31, 1969 7:20 P.M.  |  |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                                     | 22F. HOW DID INJURY OCCUR? Multiple gunshot wounds and stab wounds of body   |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                     |  |  |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.  |                                     | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |  |
| DATE SIGNED 11/1/69   |                                     |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial   |                                     | 24B. DATE 11-5-69  |  |
| 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cent  |                                     | 24D. LOCATION (City, town, or county) (State) Balto Md   |  |
| 25A. DATE REC'D BY HEALTH DEPT. NOV 3 1969  |                                     | 25B. NAME OF REGISTRAR Robert E. Fisher, M.D.  |  |
| 25C. FUNERAL DIRECTOR   |                                     | ADDRESS  |  |

1901 23

1901 23

WALTER E. PROFF

WALTER E. PROFF

WALTER E. PROFF

1901 23

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                  |  |                                   | REG. NO. 69 10802  |  |
|---|------------------|--|-----------------------------------|--|--|
| BIRTH NO. 69 10802  |                  | CERTIFICATE OF DEATH   |                                   | REG. NO. 69 10802  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>TREME YOUNG</b>   |                  | 2. DATE AND HOUR OF DEATH<br><b>4/2/69 1:40 P. M.</b>  |                                   |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>42 Sinai Hosp.</b>  |                  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>1511</b><br>C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>4030 Annallan Road</b> |                                   |  |  |
| 5. SEX <b>F</b>   | 6. RACE <b>N</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>7-4-09</b> | 9. AGE (In years lost birthday)<br><b>60</b>   | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Labo</b>  |                  | 10B. KIND OF BUSINESS OR INDUSTRY  |                                   | 11. BIRTHPLACE (State or foreign country)<br><b>Cooksville Md</b>                            |  |
| 13. FATHER'S NAME<br><b>Robert Powell</b>   |                  | 14. MOTHER'S MAIDEN NAME<br><b>Grace Miles</b>   |                                   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                  | 16. SOCIAL SECURITY NO.  |                                   | 17. INFORMANT<br><b>Isaac C Young Jr.</b> ADDRESS <b>Same</b>                                |  |
| 18. <b>412.21</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the made of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF: <b>uremia</b><br>(B) <b>Chronic renal insufficiency</b><br>DUE TO, OR AS A CONSEQUENCE OF: <b>H A S C U D</b><br>(C) <b>Chs. CHF</b>  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>years</b><br><b>years</b><br><b>years</b> |  |
| MEDICAL CERTIFICATION<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>Chs. CHF</b>  |                  |  |                                   |  |  |
| 19A. DATE OF OPERATION<br><b>0</b> <b>None</b>  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                   | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                                   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                     |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                                   | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) lost saw the deceased olive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                  |  |                                   |  |  |
| 23A. SIGNATURE<br><b>Oscar E. Laborda M.D.</b>  |                  |  |                                   | 23B. DATE SIGNED   |  |
| 23C. PHYSICIAN'S NAME (Type) <b>OSCAR E. LABORDA M.D.</b>   |                  |  |                                   | 23D. ADDRESS<br><b>SINAI Hospital</b>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Buried</b>   |                  | 24B. DATE<br><b>11-7-69</b>  |                                   | 24C. NAME OF CEMETERY or CREMATORY<br><b>Cooksville Cmt</b>                                  |  |
| 24D. LOCATION<br><b>Maryland</b>  |                  | 24E. LOCATION (City, town, or county) (State)  |                                   |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 3 1969</b>  |                  | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher, M.D.</b>  |                                   | 25C. FUNERAL DIRECTOR<br><b>Elmer B. Wilson</b> ADDRESS <b>Baltimore</b>                     |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                         |  |                                    | REG. NO. 69 10803   |   |
|---|-------------------------|--|------------------------------------|---|---|
| C-416 69 10803  |                         | CERTIFICATE OF DEATH   |                                    |   |   |
| BIRTH NO.   |                         | 1. NAME OF DECEASED<br>(Type or Print) <b>HOUSTON E. COLBERT</b>   |                                    | 2. DATE AND HOUR OF DEATH<br><b>10-26-69 1 43e M.</b>   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD</b><br>B. COUNTY <b>Howard</b>   |                                    | 5. CITY OR TOWN <b>JESSUP</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>UNIVERSITY of MARYLAND HOSPITAL</b>  |                         | E. STREET AND NUMBER<br><b>70 BOX 72</b>   |                                    | F. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                  |   |
| 5. SEX<br><b>Male</b>   | 6. RACE<br><b>Negro</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>8-20-14</b> | 9. AGE (In years last birthday)<br><b>56</b>  | If Under 1 Yr. Months Days<br>If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                         | 10B. KIND OF BUSINESS OR INDUSTRY  |                                    | 11. BIRTHPLACE (State or foreign country)   |   |
| 13. FATHER'S NAME   |                         | 14. MOTHER'S MAIDEN NAME<br><b>Minnie</b>  |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |                         | 16. SOCIAL SECURITY NO.  |                                    | 17. INFORMANT ADDRESS   |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>CARDIAC ARREST DUE TO HYPO GLYCEMIC SHOCK due to chronic liver disease and starvation</b>                               |                         | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>GLYCEMIC SHOCK due to chronic liver disease and starvation</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>and starvation</b><br>(C) _____ |                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>11 hours</b>   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                         |  |                                    |   |   |
| 19A. DATE OF OPERATION  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                    | 20A. AUTOPSY? (Yes or No) <b>No</b>   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                                    | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>9-25 1969</b> to <b>9-26 1969</b> , that (I) (we) last saw the deceased alive on <b>9-26 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |  |                                    |   |   |
| 23A. SIGNATURE<br><b>Robert E. Aquino</b>   |                         |  |                                    | 23B. DATE SIGNED<br><b>9-26-69</b>  |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>MARCOS A. AQUINO</b>   |                         |  |                                    | 23D. ADDRESS<br><b>501 E. 39 St - Baltimore - Md</b>  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                         | 24B. DATE<br><b>10/30/69</b>   |                                    | 24C. NAME OF CEMETERY or CREMATORY<br><b>Queens Chapel Cemetery</b>   |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>Murkirk, Md.</b>  |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 3 1969</b>   |                                    | 25B. NAME OF REGISTRAR<br><b>Robert E. Aquino</b>   |   |
| 25C. FUNERAL DIRECTOR<br><b>Robert E. Aquino</b>  |                         | 25D. ADDRESS<br><b>Rockville, Md.</b>  |                                    |   |   |





69 10804

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

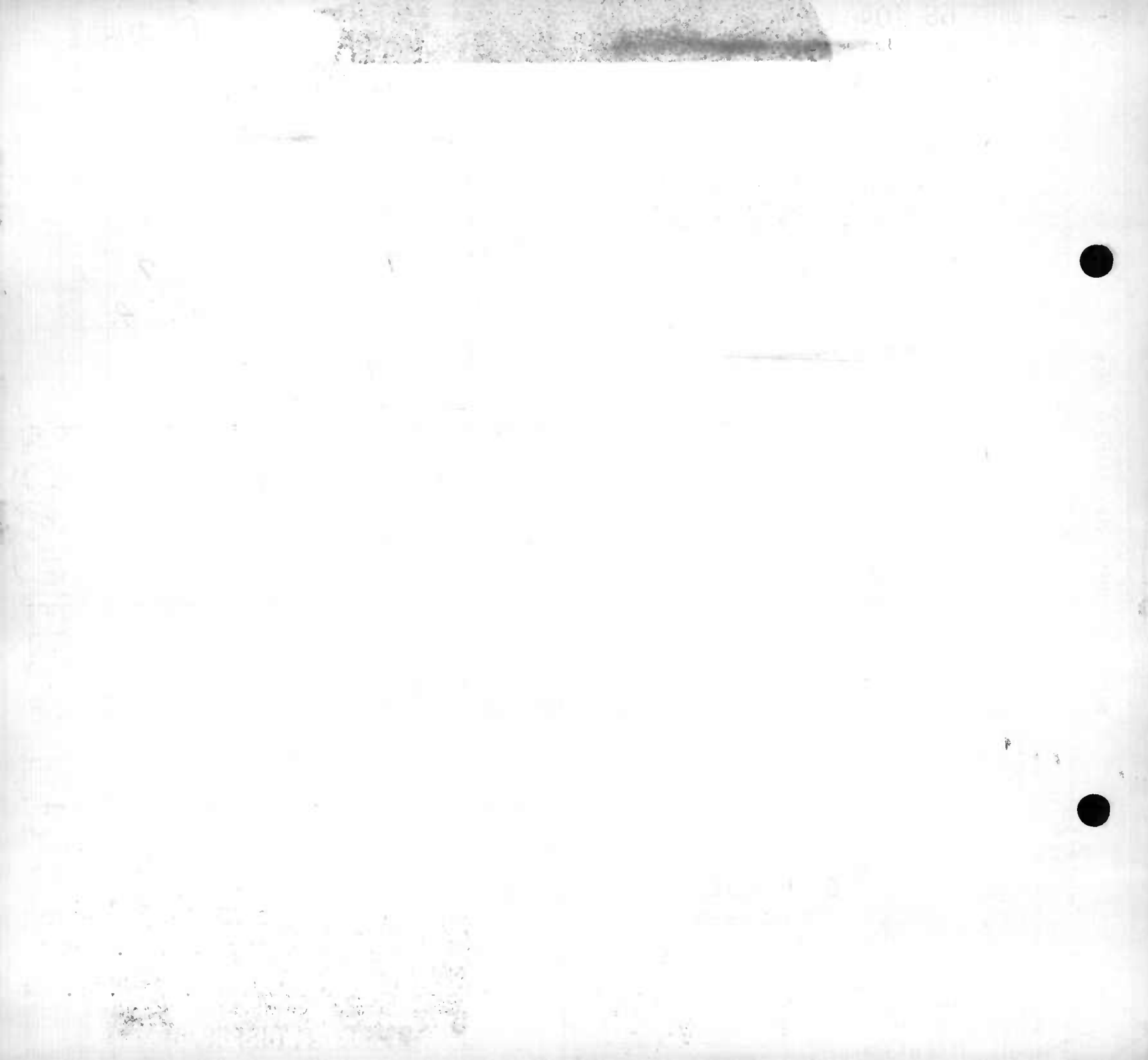
REG. NO.

69 10804

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |  |  |
|--|--|--|--|
| BIRTH NO. 19-18  |  | REG. NO. 10844   |  |
| 1. NAME OF DECEASED<br>(Type or Print) Mason Baby Girl   |  | 2. DATE AND HOUR OF DEATH<br>10/13/69 midnight   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland B. COUNTY 2542  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br>Baltimore City Hospital<br>4940 Eastern Avenue<br>Baltimore, Maryland 21224 |  | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES [X] NO [ ]  |  |
| 5. SEX Female  |  | 6. RACE Negro  |  |
| 7. MARRIED [ ] NEVER MARRIED [X]<br>WIDOWED [ ] DIVORCED [ ]   |  | 8. DATE OF BIRTH 10-6-69   |  |
| 9. AGE (In years last birthday) 7  |  | 10. UNDER 1 Yr. Months 7   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (State or foreign country) Baltimore Md   |  | 12. CITIZEN OF WHAT COUNTRY? U.S.A.  |  |
| 13. FATHER'S NAME  |  | 14. MOTHER'S MAIDEN NAME Beverly Mason   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No  |  | 16. SOCIAL SECURITY NO. 6  |  |
| 17. INFORMANT BCH-Records  |  | ADDRESS 4940 Eastern Avenue<br>Baltimore, Maryland 21224   |  |
| 18. 759.41 CAUSE OF DEATH  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH   |  | (A) IMMEDIATE CAUSE Cardiorespiratory failure  |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   |  | DUE TO, OR AS A CONSEQUENCE OF:  |  |
| ANTECEDENT CAUSES  |  | (B) Chromosomal abnormality  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  | DUE TO, OR AS A CONSEQUENCE OF:  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  | (C)  |  |
| 19A. DATE OF OPERATION 2-10  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20A. AUTOPSY? (Yes or No) Yes  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  | 21D. HOW DID INJURY OCCUR?   |  |
| 21E. INJURY OCCURRED While At [ ] Not While At Work [ ]  |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from 10/6/69 to 10/13/69  |  | that (I) (we) lost saw the deceased alive on 10/13/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |
| 23A. SIGNATURE C. Krush  |  | 23B. DATE SIGNED 10/14/69  |  |
| 23C. PHYSICIAN'S NAME (Type) Carol Krush   |  | 23D. ADDRESS Baltimore City Hospitals<br>4940 Eastern Avenue Baltimore, Md. 21224  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Cremation   |  | 24B. DATE 10/15/69   |  |
| 24C. NAME OF CEMETERY or CREMATORY Baltimore City Hospitals  |  | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. #24   |  |
| 25A. DATE RECEIVED BY HEALTH DEPT. NOV 4 1969  |  | 25B. NAME OF REGISTRAR   |  |
| 25C. FUNERAL DIRECTOR  |  | ADDRESS  |  |



B-632

69 10805

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 10805

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ELWOOD BRATCHER

2. DATE AND HOUR OF DEATH

10/5/69

1 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITALS

4940 EASTERN AVENUE

BALTIMORE, MARYLAND

#21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN  
BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1931 EAST FAYETTE STREET

5. SEX

MALE

6. RACE

NERGO

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

8-27-02

9. AGE (In years  
last birthday)

67

If Under 1 Yr.  
Months DaysIf Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

DELAWARE

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

221

16. SOCIAL  
SECURITY NO.  
10-1260 A

17. INFORMANT

ADDRESS

RECORDS: BALTIMORE CITY HOSPITALS

4940 EASTERN AVENUE #21224

18. 162.1 I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

RESPIRATORY INSUFFICIENCY

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) PNEUMONIA

DUE TO, OR AS A CONSEQUENCE OF:

(C) CARCINOMA OF LUNG

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

24h.

48h

&gt; 1 month.

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

3.9/24/69

PULMONARY OBSTRUCTION

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)

NO

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8/22/69 19 to 10/5/69 19  
that (I) (we) last saw the deceased alive on 10/5/69 19 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

DEGREE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

10-5-69

23C. PHYSICIAN'S  
NAME (Type)

E. CASANO MD

DEGREE

23D. ADDRESS

BALTIMORE BOARD OF HEALTH  
UNIVERSITY MEDICAL SCHOOL24A. BURIAL CREMATION  
REMOVAL (Specify)

24B. DATE

10-28-69

24C. NAME OF CEMETERY or CREMATION

Richmond Va

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 4 1969

25B. NAME OF REGISTRAR

Robert E. [Signature]

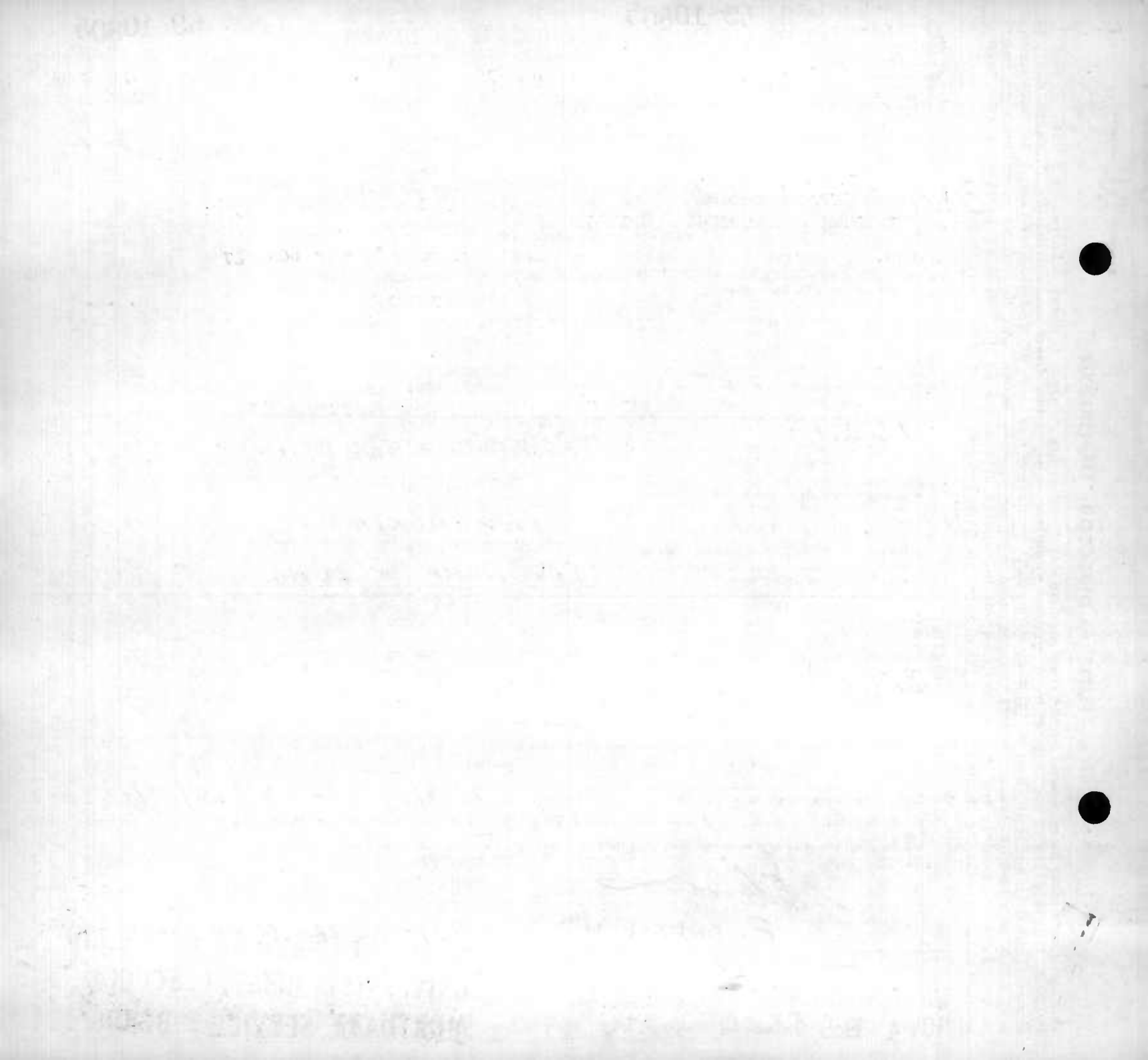
25C. FUNERAL DIRECTOR

MORTUARY SERVICE - BCHD

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



G-620

69 10806

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 10806

|   |                         |  |   |  |  |
|---|-------------------------|--|---|--|--|
| BIRTH NO.   |                         | 1. NAME OF DECEASED<br>(Type or Print) <b>JAMES GEORGE</b>   |   | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> M.                        |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>37 Mercy Hospital</b>  |                         | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>October 14, 1969 3:30 P.</b>  |   | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>401</b> |  |
| 6. SEX<br><b>Male</b>   | 7. RACE<br><b>Negro</b> | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |   | C. CITY OR TOWN<br><b>Baltimore</b>  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 9. DATE OF BIRTH  |                         | 10. AGE (In years last birthday)<br><b>50?</b>   | 11. BIRTHPLACE (State or foreign country) |  | 12. CITIZEN OF WHAT COUNTRY?   |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                         | 14B. KIND OF BUSINESS OR INDUSTRY  |   | 15. MOTHER'S MAIDEN NAME   |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)   |                         | 17. SOCIAL SECURITY NO.  |   | 18. INFORMANT ADDRESS  |  |
| 19. <b>E988 X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |                         | CAUSE OF DEATH<br><b>Craniocerebral Injuries</b><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) DUE TO, OR AS A CONSEQUENCE OF: |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                       |
| 20A. DATE OF OPERATION  |                         | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 21. AUTOPSY? (Yes or No)<br><b>yes</b>   |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                         | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Unk.</b>  |   | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br><b>Found in 600 Block of Pratt Street</b>                  |  |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)<br><b>Oct. 1969</b>   |                         | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |   | 22F. HOW DID INJURY OCCUR?<br><b>Unk.</b>  |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/><br><br>ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>10/15/69</b><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |                         |  |   |  |  |
| 24A. BURIAL CREMATION REMOVAL (Specify)   |                         | 24B. DATE<br><b>10.31.69</b>   |   | 24C. NAME OF CEMETERY or CREMATOR<br><b>Richmond, Va</b>   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 4 1969</b>  |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>  |   | 25C. FUNERAL DIRECTOR ADDRESS<br><b>UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD</b>  |  |

11854.6 9890008791

April 20

April 20

April 20

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. <u>69-18828</u>   |                         |   |  | BALTIMORE CITY HEALTH DEPARTMENT  |   | REG. NO. <u>69 10807</u>   |  |
|---|-------------------------|---|--|---|---|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <u>BABY BOY HUGHES</u>   |                         |   |  | 2. DATE AND HOUR OF DEATH<br><u>10-16-69</u> <u>8:30 A.M.</u>   |   |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>37 Mercy Hospital</u>   |                         |   |  | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <u>MD</u> B. COUNTY <u>21202</u><br>C. CITY OR TOWN <u>Balto</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <u>1016 Sterling St</u> |   |  |  |
| 5. SEX<br><u>Male</u>   | 6. RACE<br><u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>10-10-69</u>  | 9. AGE (In years last birthday)<br><u>6</u>   | If Under 1 Yr. Months Days<br><u>6</u>                    | If Under 24 Hrs. Hours Min.<br><u>30</u>                             |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                         |   | 10B. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)<br><u>Balto</u> |  |  |
| 12. CITIZEN OF WHAT COUNTRY?  |                         |   | 13. FATHER'S NAME<br><u>None ?</u>   |   |   |  |  |
| 14. MOTHER'S MAIDEN NAME<br><u>Yvonne Hughes</u>  |                         |   | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) |   |   |  |  |
| 16. SOCIAL SECURITY NO.   |                         |   | 17. INFORMANT ADDRESS  |   |   |  |  |
| 18. <u>038.9 I</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>Generalized Prematurity</u><br><u>Mild dehydration</u><br><u>possible sepsis</u> |                         |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |                         |   |  |   |   |  |  |
| 19A. DATE OF OPERATION<br><u>10-16-69</u>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>no</u>   |  | 20A. AUTOPSY? (Yes or No)<br><u>no</u>  |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)   |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |   |  |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)  |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |   |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10-10-69</u> to <u>10-16-69</u> and that (I) (we) last saw the deceased alive on <u>10-16-69</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                         |   |  |   |   |  |  |
| 23A. SIGNATURE<br><u>Dante P. Gabriel M.D.</u>  |                         |   |  | 23B. DATE SIGNED  |   |  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>DANTE P. GABRIEL</u>   |                         |   |  | 23D. ADDRESS<br><u>ANATOMY BOARD OF MARYLAND</u><br><u>UNIVERSITY MEDICAL SCHOOL</u>  |   |  |  |
| 24A. BURIAL CREMATION REMOVAL (Specify)   |                         | 24B. DATE<br><u>10-28-69</u>  |  | 24C. NAME of CEMETERY or CREMATION  |   | 24D. LOCATION (City, town, or county) (State)                        |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 4 1969</u>  |                         | 25B. NAME OF REGISTRAR<br><u>Robert E. Galt</u>   |  | 25C. FUNERAL DIRECTOR<br><u>MORTUARY SERVICE</u>  |   | 25D. ADDRESS   |  |





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

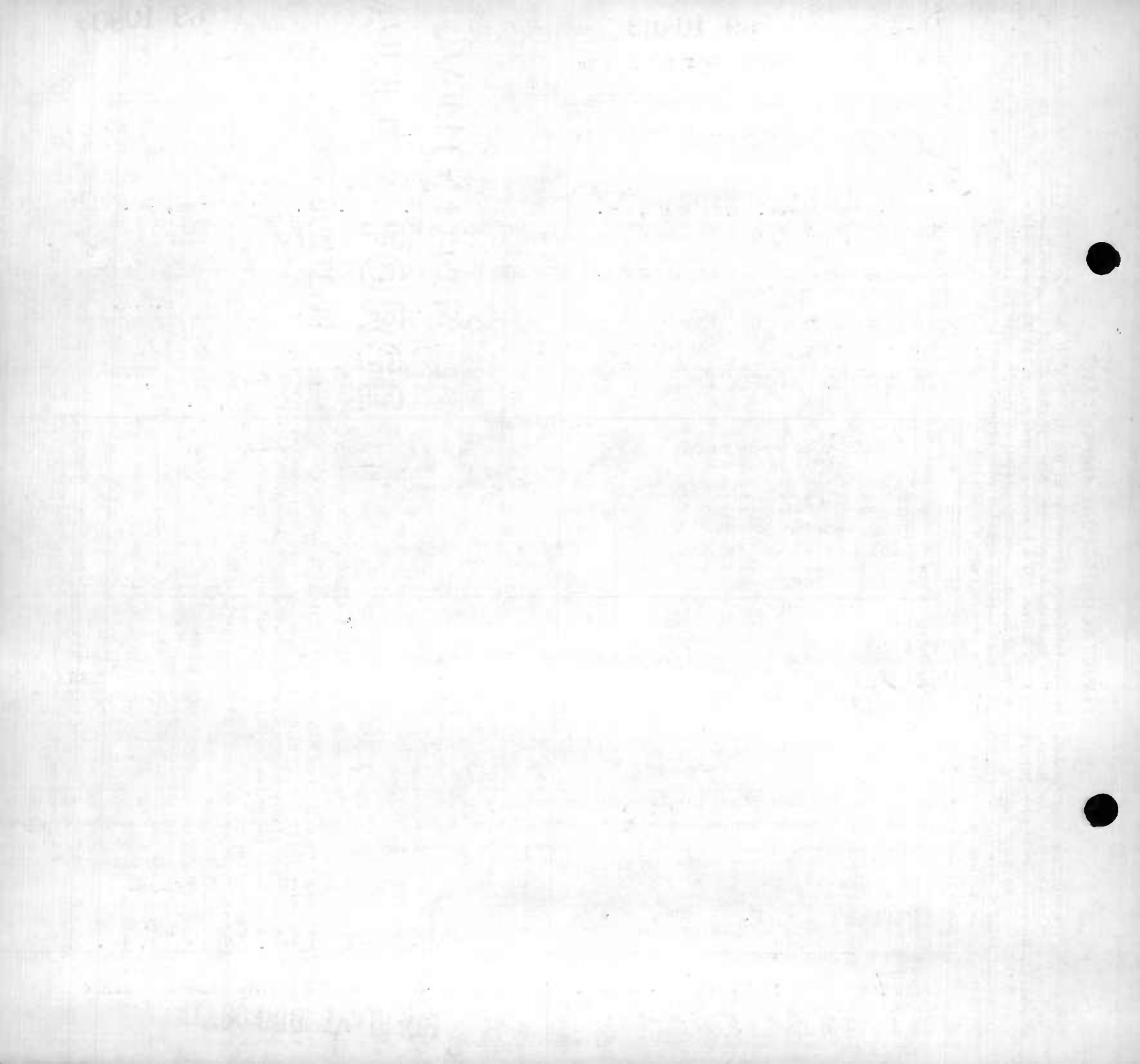
|  |                  |  |   |   |   |
|--|------------------|--|---|---|---|
| BIRTH NO. <b>K-163</b>   |                  | BALTIMORE CITY HEALTH DEPARTMENT   |   | REG. NO. <b>69 10808</b>  |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>BABY GIRL ROBERTS</b>  |                  |  | 2. DATE AND HOUR OF DEATH<br><b>OCTOBER 22 1969 10:45 A.M.</b>  |   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>SOUTH BALTIMORE GENERAL HOSPITAL</b><br><b>43</b>  |                  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>G. G. C.</b><br>C. CITY OR TOWN <b>Glen Burnie</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>7635 9th Ct.</b> |   |   |
| 5. SEX <b>F</b>  | 6. RACE <b>N</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>OCTOBER 20, 1968</b>  | 9. AGE (In years last birthday) <b>0</b>                                  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>INFANT</b>   |                  | 10B. KIND OF BUSINESS OR INDUSTRY  | 11. BIRTHPLACE (State or foreign country)<br><b>UNITED STATES</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>      |
| 13. FATHER'S NAME<br><b>MICHAEL ROBERTS</b>  |                  |  | 14. MOTHER'S MAIDEN NAME<br><b>CORINNE BENTZ</b>  |   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |                  | 16. SOCIAL SECURITY NO.  | 17. INFORMANT ADDRESS   |   |   |
| 18. <b>776.1 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br><b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertension</b><br><b>(B) DUE TO, OR AS A CONSEQUENCE OF: Permaternity</b><br><b>(C) ...</b> |                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                  |  |   |   |   |
| 19A. DATE OF OPERATION <b>0</b>  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No) <b>No.</b>                                      |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |   | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 20 19 69</b> to <b>OCTOBER 22 19 69</b> , that (I) (we) last saw the deceased alive on <b>OCTOBER 22 19 69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                  |  |   |   |   |
| 23A. SIGNATURE<br><b>Estrellita P. Travis M.D.</b>   |                  |  | 23B. DATE SIGNED<br><b>OCTOBER 22 1969</b>  |   |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>ESTRELLITA P. TRAVIS M.D.</b>   |                  |  | 23D. ADDRESS<br><b>ANATOMY BOARD OF MARYLAND</b>  |   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |                  | 24B. DATE<br><b>10-31-69</b>   |   | 24C. NAME of CEMETERY or CREMATORY<br><b>JOHNS HOPKINS MEDICAL SCHOOL</b> |   |
| 24D. LOCATION (City, town, or county) (State)  |                  | 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 4 1969</b>   |   |   |   |
| 25B. NAME OF REGISTRAR<br><b>Robert E. ...</b>   |                  | 25C. FUNERAL DIRECTOR ADDRESS<br><b>MORTUARY SERVICE - BCHO</b>  |   |   |   |



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |               |   |                           |  |   |
|---|---------------|---|---------------------------|--|---|
| D-200 69 10809  |               | BALTIMORE CITY HEALTH DEPARTMENT  |                           | REG. NO. 69 10809  |   |
| BIRTH NO. 69-19565  |               | 1. NAME OF DECEASED DIGGS, BABY BOY, OLGA<br>(Type or Print) 31645 Baby Boy Olga  |                           | 2. DATE AND HOUR OF DEATH 10-26-69 4:45 P.M.   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |               | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland  |                           | D. INSIDE CITY LIMITS? 907<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS<br>4940 Eastern Ave. Baltimore, Md. 21224  |               | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |                           | C. CITY OR TOWN Baltimore<br>E. STREET AND NUMBER 1519 E. 28th. St. Baltimore, Md. 21218 007   |   |
| 5. SEX Male   | 6. RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                       | 8. DATE OF BIRTH 10-26-69 | 9. AGE (In years lost birthday)  | If Under 1 Yr. Months Days<br>If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |               | 10B. KIND OF BUSINESS OR INDUSTRY   |                           | 11. BIRTHPLACE (State or foreign country) Maryland<br>12. CITIZEN OF WHAT COUNTRY? U.S.A.  |   |
| 13. FATHER'S NAME William Diggs   |               | 14. MOTHER'S MAIDEN NAME Olga Recca Clark   |                           | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                       |   |
| 16. SOCIAL SECURITY NO.   |               | 17. INFORMANT BCH Records: 4940 Eastern Ave. Baltimore, Md. 21224   |                           | ADDRESS  |   |
| 18. 772.0 I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |               | CAUSE OF DEATH<br>Severe Brain Hemorrhage<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF: |                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |               |   |                           |  |   |
| 19A. DATE OF OPERATION 22   |               | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                           | 20A. AUTOPSY? (Yes or No) YES<br>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES                                      |   |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)   |               | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                           | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |               | 21E. INJURY OCCURRED<br>While At <input type="checkbox"/> Nat White At Work <input type="checkbox"/>  |                           | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from 10-26-69 19 to 10-26 1969, that (I) (we) last saw the deceased alive on 10-26 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                   |               |   |                           |  |   |
| 23A. SIGNATURE<br>Alvarez   |               | 23B. DATE SIGNED<br>10-26-69  |                           | 23C. PHYSICIAN'S NAME (Type) M. Alvarez, MD.<br>23D. ADDRESS<br>4940 Eastern Ave. Baltimore, Md. 21224   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify) CREMATED   |               | 24B. DATE 10/28/69  |                           | 24C. NAME of CEMETERY or CREMATORY BALTIMORE CITY HOSPITALS<br>24D. LOCATION (City, town, or county) BALTIMORE, MARYLAND<br>24E. ADDRESS 21224 |   |
| 25A. DATE REC'D BY HEALTH DEPT. NOV 4 1969  |               | 25B. NAME OF REGISTRAR Robert E. Palmer, Jr.  |                           | 25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL  |   |



# FUNERAL DIRECTOR: IMPORTANT

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| BALTIMORE CITY HEALTH DEPARTMENT  |                     |   |   | REG. NO. <span style="font-size: 1.2em;">69 10810</span>                 |   |
|---|---------------------|---|---|--|---|
| <div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.5em;">H-325</span> <span style="font-size: 1.5em;">69 10810</span> <span style="font-size: 1.5em;">CERTIFICATE OF DEATH</span> </div>  |                     |   |   |  |   |
| BIRTH NO. _____   |                     |   |   |  |   |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Julia D. Hitchings</i>  |                     |   | 2. DATE AND HOUR OF DEATH<br><i>Nov. 2, 1969</i> <span style="float: right;"><i>8:10</i> M.</span>  |  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                     |   | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)   |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>Montebello State Hospital</i>  |                     |   | A. STATE <i>Maryland</i> B. COUNTY <i>1102</i>  |  |   |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |                     |   | C. CITY OR TOWN<br><i>Baltimore</i>   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|   |                     |   | E. STREET AND NUMBER<br><i>212 W. Monument Street</i>   |  |   |
| 5. SEX<br><i>F</i>  | 6. RACE<br><i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>10-4-80</i>  | 9. AGE (In years last birthday) <i>89</i>                                | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Companion (old people)</i>  |                     |   | 11. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |
| 13. FATHER'S NAME<br><i>Charles Danforth</i>  |                     |   | 14. MOTHER'S MAIDEN NAME<br><i>Marion Ashor</i>   |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>Unknown</i>  |                     |   | 16. SOCIAL SECURITY NO.<br><i>267-12-2757</i>   | 17. INFORMANT ADDRESS<br><i>Hospital Chart.</i>                          |   |
| 18. <i>410.9</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                     |   | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><i>Coronary occlusion</i><br>(B) <i>Arteriosclerotic heart disease</i><br>(C) <i>Cause unknown</i> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>seconds</i><br><i>years</i>                |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                     |   |   |  |   |
| 19A. DATE OF OPERATION<br><i>0</i>  |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)<br><i>No</i>                                   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME OF INJURY (APPROX.)   |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |   | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <i>3-1 1966</i> to <i>11-2 1969</i> , that (I) (we) lost saw the deceased alive on <i>11-2 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                        |                     |   |   |  |   |
| 23A. SIGNATURE<br><i>Cesar J. Pellerano M.D.</i>  |                     |   |   | 23B. DATE SIGNED<br><i>11-2-69</i>                                       |   |
| 23C. PHYSICIAN'S NAME (Type)<br><i>Cesar J. Pellerano M.D.</i>  |                     |   |   | 23D. ADDRESS<br><i>Montebello State Hospital</i>                         |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Cremation</i>  |                     | 24B. DATE<br><i>11/4/69</i>   |   | 24C. NAME of CEMETERY or CREMATORY<br><i>Greenmount</i>                  |   |
| 24D. LOCATION (City, town, or county) (State)<br><i>Baltimore, Maryland</i>   |                     | 25A. DATE REC'D BY HEALTH DEPT.<br><i>NOV 4 1969</i>  |   |  |   |
| 25B. NAME OF REGISTRAR<br><i>Robert J. ...</i>  |                     | 25C. FUNERAL DIRECTOR ADDRESS<br><i>Donald J. ... Inc. Baltimore, Maryland</i>  |   |  |   |

Dear Sir,  
I have the pleasure to inform you that  
the order for the purchase of the  
following goods has been placed  
with the firm of Messrs. J. & W. Smith  
of London, and the goods are  
being forwarded to you by  
the first opportunity.

Yours faithfully,  
J. & W. Smith

Enclosed for you are the  
following documents:

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                             |   |                                   | 69 10811  |                             |
|---|-----------------------------|---|-----------------------------------|---|-----------------------------|
| 69 10811 CERTIFICATE OF DEATH   |                             |   |                                   | REG. NO. 69 10811   |                             |
| BIRTH NO.   |                             | 1. NAME OF DECEASED<br>(Type or Print) <u>Robert R. Brewer</u>  |                                   | 2. DATE AND HOUR OF DEATH<br><u>10-31-69</u> <u>9:10</u> A.M.                                 |                             |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                             | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)   |                                   |   |                             |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>Union Memorial Hosp.</u>   |                             | A. STATE<br><u>Maryland</u>   |                                   | B. COUNTY<br><u>2733</u>  |                             |
| IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION  |                             | C. CITY OR TOWN<br><u>Baltimore, Md.</u>  |                                   | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                             |
| E. STREET AND NUMBER<br><u>3210 Batavia Ave.</u>  |                             |   |                                   |   |                             |
| 5. SEX<br><u>M</u>  | 6. RACE<br><u>Caucasian</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                   | 8. DATE OF BIRTH<br><u>6-8-93</u> | 9. AGE (in years last birthday) <u>76</u>   | II Under 1 Yr. 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Ret. Balto. City Sanitation Dept.</u>   |                             | 10B. KIND OF BUSINESS OR INDUSTRY   |                                   | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>                                  |                             |
| 13. FATHER'S NAME<br><u>Isaac F. Brewer</u>   |                             | 14. MOTHER'S MAIDEN NAME<br><u>Anne Clark</u>   |                                   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>no</u>   |                             | 16. SOCIAL SECURITY NO.<br><u>212-10-5770A</u>  |                                   | 17. INFORMANT<br><u>Mazzie Maggio</u> same  |                             |
| 18. <u>188X I</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.    |                             | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br><u>Renal failure.</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <u>Tumor of the urinary bladder.</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____ |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>D.H.</u>                                   |                             |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |                             |   |                                   |   |                             |
| 19A. DATE OF OPERATION<br><u>10-9-69</u>  |                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>Prostatectomy; Hematuria</u>   |                                   | 20A. AUTOPSY? (Yes or No)   |                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |                             |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                             | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                                   | 21F. HOW DID INJURY OCCUR?  |                             |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9-29</u> 19 <u>69</u> to <u>10-31</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>10-31</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                             |   |                                   |   |                             |
| 23A. SIGNATURE<br><u>Robert R. Brewer</u>   |                             |   |                                   | 23B. DATE SIGNED<br><u>10-31-69</u>   |                             |
| 23C. PHYSICIAN'S NAME (Type)<br><u>Robert R. Brewer</u>   |                             |   |                                   | 23D. ADDRESS<br><u>UNION MEMORIAL HOSPITAL</u>  |                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                             | 24B. DATE<br><u>11/3/69</u>   |                                   | 24C. NAME of CEMETERY or CREMATORY<br><u>Oaklawn Cemetery</u>                                 |                             |
| 24D. LOCATION<br><u>Balto. Md.</u>  |                             | 24E. DATE REC'D BY HEALTH DEPT.<br><u>NOV 4 1969</u>  |                                   | 24F. NAME OF REGISTRAR<br><u>Robert R. Brewer</u>   |                             |
| 24G. DATE REC'D BY HEALTH DEPT.<br><u>NOV 4 1969</u>  |                             | 24H. NAME OF REGISTRAR<br><u>Robert R. Brewer</u>   |                                   | 24I. FUNERAL DIRECTOR<br><u>Leonard J. Ruck Inc.</u>  |                             |
| 24J. ADDRESS<br><u>Balto. Md.</u>   |                             | 24K. ADDRESS<br><u>Balto. Md.</u>   |                                   | 24L. ADDRESS<br><u>Balto. Md.</u>   |                             |

2210 Burton Ave  
Baltimore, Md  
6-8-43  
Maryland  
Anne Clark  
USA

M  
Concession  
Isaac T. Brown

10-24-43

10-24-43

10-24-43

10-24-43

10-24-43

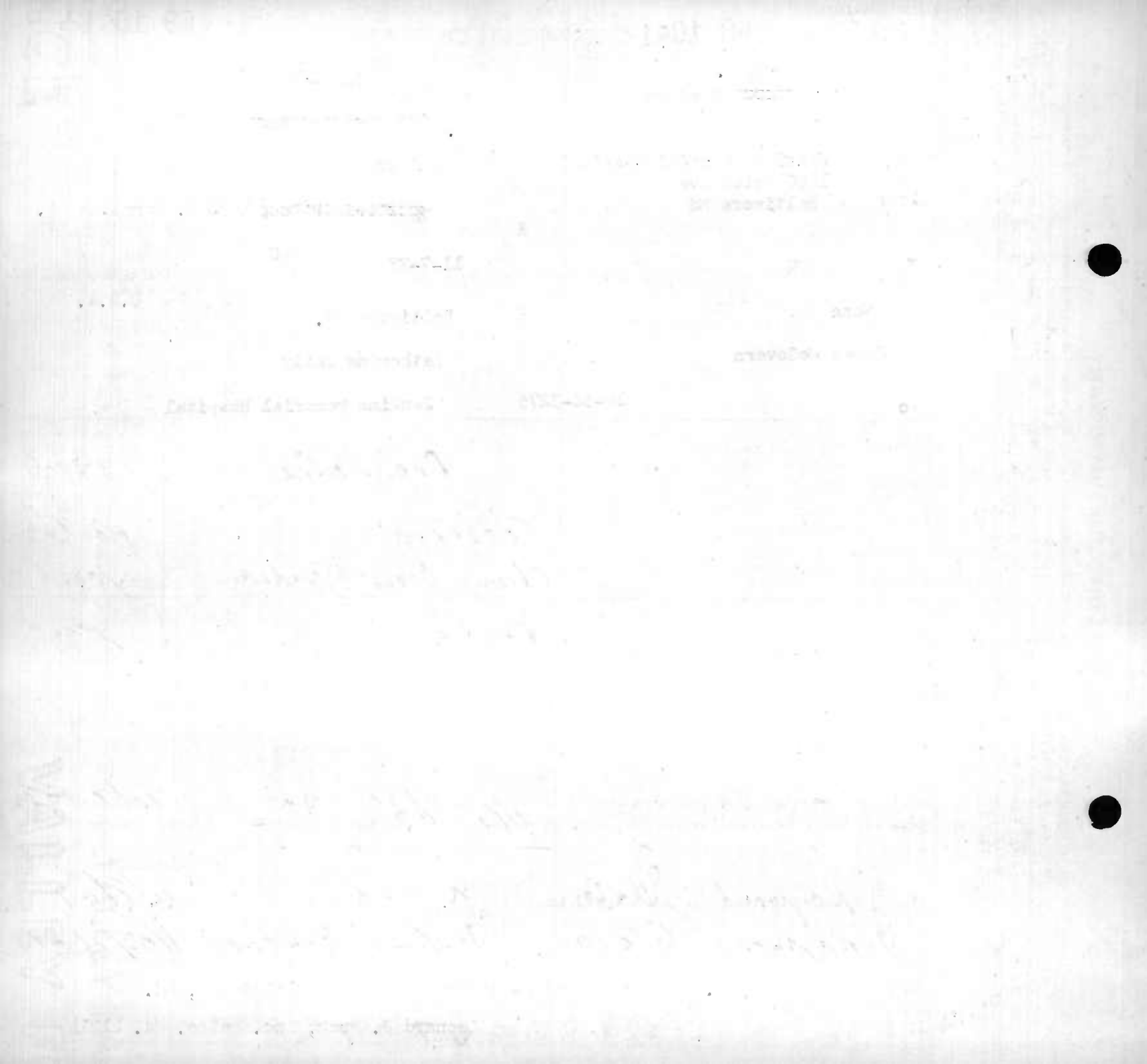
10-24-43



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |              |   |  |  |  |  |  |
|--|--------------|---|--|--|--|--|--|
| M-216  |              | 69 10812  |  | CERTIFICATE OF DEATH   |  | REG. NO. 69 10812  |  |
| BIRTH NO.  |              |   |  | 1. NAME OF DECEASED<br>(Type or Print) Anne L. <del>Miss Anne L. McGovern</del>  |  |  |  |
| 2. DATE AND HOUR OF DEATH<br>11-1-69   |              |   |  | 7 A M.   |  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |              |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>91 Jenkins Memorial Hospital<br>1000 Caton Ave<br>Baltimore Md   |              |   |  | E. STREET AND NUMBER<br><del>7032 Belair Road</del> 1520 N. Caroline St.   |  |  |  |
| 5. SEX<br>F  | 6. RACE<br>W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>11-7-78  | 9. AGE (In years last birthday)<br>90  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.  |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>None  |              |   | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br>Baltimore Md. |  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |              |   | 13. FATHER'S NAME<br>James McGovern  |  |  |  |  |
| 14. MOTHER'S MAIDEN NAME<br>Katherine Kelly  |              |   | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No |  |  |  |  |
| 16. SOCIAL SECURITY NO.<br>216-54-3275   |              |   | 17. INFORMANT<br>Jenkins Memorial Hospital   |  |  |  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)<br>Pneumonia  |              |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>7 weeks  |  |  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>Cochemia   |              |   |  | months   |  |  |  |
| (C) Chronic Brain Syndrom  |              |   |  | years  |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br>ASCCD  |              |   |  | years  |  |  |  |
| 19A. DATE OF OPERATION   |              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |              | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |  |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  |              | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?   |  |  |  |
| 22. I certify that (1) (this hospital) attended the deceased from 11/1/69 to 11/1/69 that (2) (we) lost saw the deceased olive on 11/1/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. |              |   |  |  |  |  |  |
| 23A. SIGNATURE<br>J. Raymond Gladue  |              |   |  | 23B. DATE SIGNED<br>11/1/69  |  | 23C. PHYSICIAN'S NAME (Type)<br>J. Raymond Gladue                    |  |
| 23D. ADDRESS<br>Jenkins Memorial Hospital  |              |   |  | 23E. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial   |              | 24B. DATE<br>11/4/69  |  | 24C. NAME of CEMETERY or CREMATORY<br>New Cathedral Cemetery   |  | 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Md.      |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 4 1969  |              | 25B. NAME OF REGISTRAR<br>Leonard J. Buck, Inc.   |  | 25C. FUNERAL DIRECTOR<br>Balto. Md. 21214  |  | ADDRESS  |  |



51-10-37

dis

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                  |   |                              |   |  |   |  |
|--|------------------|---|------------------------------|---|--|---|--|
| E-166  |                  | 69 10813  |                              | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. 69 10813   |  |
| BIRTH NO.  |                  |   |                              | 1. NAME OF DECEASED<br>(Type or Print) EVERHART, LILLIE   |  |   |  |
| 2. DATE AND HOUR OF DEATH<br>11/2/69 10 <sup>00</sup> AM   |                  |   |                              | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>BALTIMORE CITY HOSPITALS<br>4940 Eastern Avenue<br>Baltimore, Maryland 21224   |                  |   |                              | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE Maryland<br>B. COUNTY Baltimore<br>C. CITY OR TOWN Baltimore<br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER 5307 Herring Run Drive 21214 |  |   |  |
| 5. SEX<br>Female   | 6. RACE<br>White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>11-10-95 | 9. AGE (In years last birthday)<br>73   | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Min.   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Homemaker   |                  | 10B. KIND OF BUSINESS OR INDUSTRY   |                              | 11. BIRTHPLACE (State or foreign country)<br>Maryland   |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                      |  |
| 13. FATHER'S NAME<br>William Zang  |                  |   |                              | 14. MOTHER'S MAIDEN NAME<br>Elizabeth Fuchs   |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |                  | 16. SOCIAL SECURITY NO.<br>215-50-1130  |                              | 17. INFORMANT<br>BCH: Records Baltimore, Maryland 21224   |  | ADDRESS<br>4940 Eastern Avenue  |  |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTecedent CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br>ASCVD & C.H.F. |                  |   |                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |
| 19A. DATE OF OPERATION<br>2  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                              | 20A. AUTOPSY? (Yes or No)<br>Yes  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>Yes |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                              | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |  |   |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX.)   |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                              | 21F. HOW DID INJURY OCCUR?  |  |   |  |
| 22. I certify that (I) (the hospital) attended the deceased from 10/11/19 69 to 11/2/19 69, that (I) (we) lost saw the deceased alive on 11/2/19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                  |   |                              |   |  |   |  |
| 23A. SIGNATURE<br>Dennis Bleakley MD   |                  |   |                              | 23B. DATE SIGNED<br>11/2/69   |  | 23C. PHYSICIAN'S NAME (Type)<br>Dennis Bleakley M.D.                        |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial   |                  | 24B. DATE<br>11/5/69  |                              | 24C. NAME OF CEMETERY or CREMATORY<br>Oaklawn Cemetery  |  | 24D. LOCATION (City, town, or county) (State)<br>Baltimore Maryland         |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 4 1969  |                  | 25B. NAME OF REGISTRAR<br>Robert E. Fisher  |                              | 25C. FUNERAL DIRECTOR<br>Leonard J. Buck Inc.   |  | ADDRESS<br>5305 Harford Rd. 21214   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |   |  |
|--|--|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT   |  | 69 10814  |  |
| C-200  |  | 69 10814  |  |
| BIRTH NO.  |  | REG. NO.  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>PAUL COOK</b>  |  | 2. DATE AND HOUR OF DEATH<br><b>10/31/69 4:35 P.M.</b>  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                                       |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>X USPHS HOSPITAL</b>  |  | A. STATE <b>OHIO</b><br>B. COUNTY <b>V-32</b>   |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |  | C. CITY OR TOWN <b>DAYTON</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 5. SEX <b>M</b>  |  | 6. RACE <b>Cauc</b>   |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH <b>3/26/42</b>   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>POSTAL CARRIER</b>   |  | 9. AGE (In years last birthday) <b>27</b>   |  |
| 10B. KIND OF BUSINESS OR INDUSTRY<br><b>US GOVT</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>OHIO</b>  |  |
| 13. FATHER'S NAME<br><b>HARRY COOK</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>YES USA - 1964-68</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>LORENE ELLIOTT</b>   |  |
| 16. SOCIAL SECURITY NO.<br><b>27738 3997</b>   |  | 17. INFORMANT<br><b>CHART</b>   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><b>201 X I</b>   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 1. This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.  |  | (A) IMMEDIATE CAUSE<br><b>RESPIRATORY FAILURE</b>   |  |
| 2. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  | (B) <b>HODGKINS DISEASE</b>   |  |
| 3. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |  | (C) <b>—</b>  |  |
| 19A. DATE OF OPERATION <b>2/2</b>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20A. AUTOPSY? (Yes or No) <b>YES</b>   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                    |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  | 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)   |  |
| 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (if) (this hospital) attended the deceased from <b>8/10/69</b> to <b>10/31/69</b> that (if) (we) last saw the deceased alive on <b>10/31/69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (if) (We) (did) (did not) view the body after death. |  |   |  |
| 23A. SIGNATURE<br><b>GARY E. FELDMAN, M.D.</b>   |  | 23B. DATE SIGNED<br><b>11/1/69</b>  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>GARY E. FELDMAN, M.D.</b>   |  | 23D. ADDRESS<br><b>USPHS HOSPITAL BALTO.</b>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Entombment</b>  |  | 24B. DATE<br><b>11/5/69</b>   |  |
| 24C. NAME of CEMETERY or CREMATORY<br><b>Miami Valley Mem Gdns</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>Centerville, Dayton, Ohio</b>   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 4 1969</b>   |  | 25B. NAME OF REGISTRAR<br><b>Leonard J. Ruck</b>  |  |
| 25C. FUNERAL DIRECTOR<br><b>Leonard J. Ruck Inc.</b>   |  | ADDRESS<br><b>Balto. Md.</b>  |  |

James H. Smith

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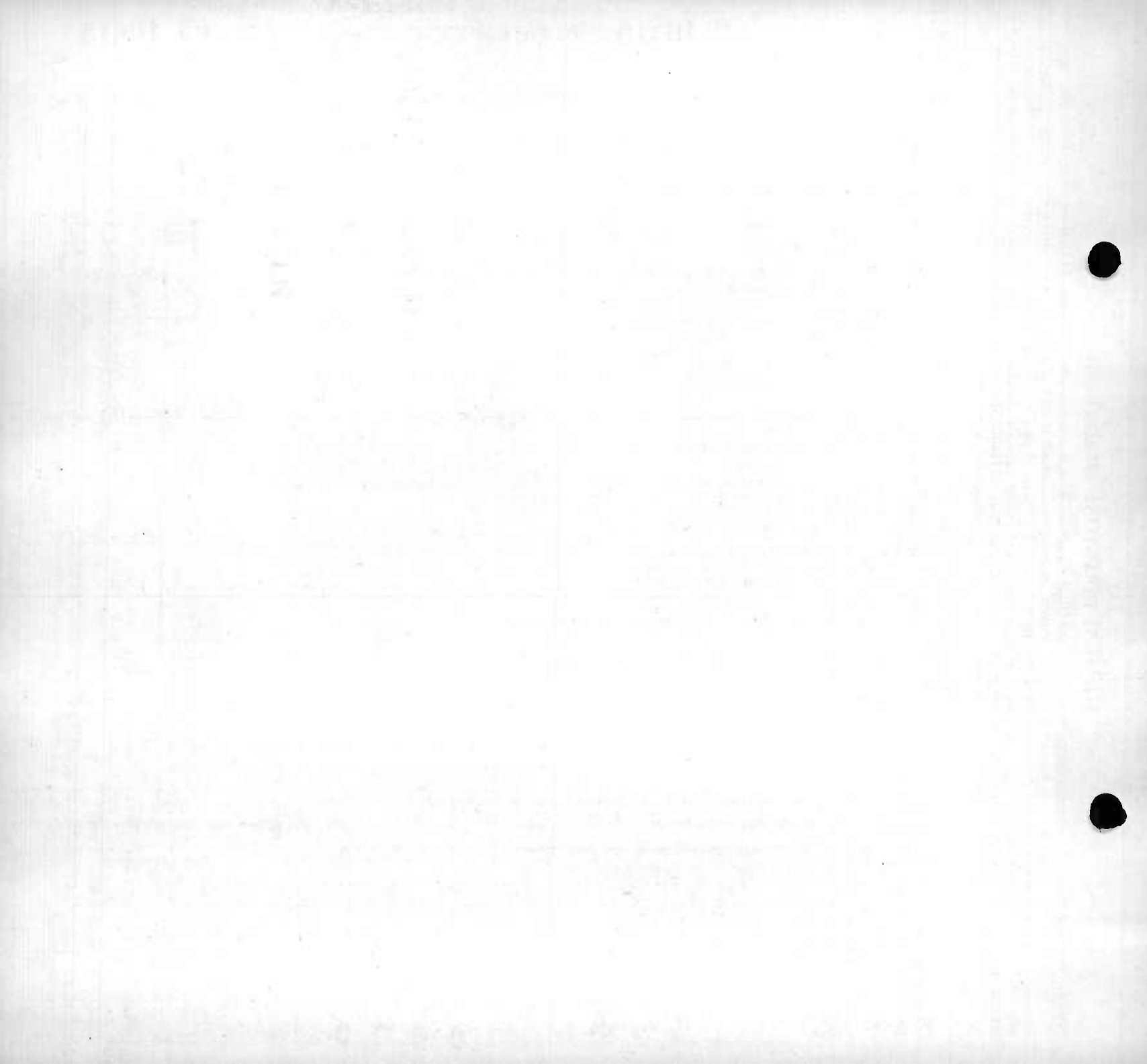
James H. Smith

James H. Smith

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| W-410  |                         |   |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | REG. NO. 69 10815   |  |
|--|-------------------------|---|--|--|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Gertrude A. Wolff</i>  |                         |   |  | 2. DATE AND HOUR OF DEATH<br><i>Nov 3rd 69</i> <i>5 A.M.</i>   |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                         |   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <i>md.</i> B. COUNTY <i>2101</i>   |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><i>788 Washington Blvd.</i>   |                         |   |  | C. CITY OR TOWN<br><i>Baltimore</i>  |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
|  |                         |   |  | E. STREET AND NUMBER<br><i>788 Washington Blvd (21230).</i>  |  |   |  |
| 5. SEX<br><i>Female</i>  | 6. RACE<br><i>white</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><i>10-9-86</i>   |  | 9. AGE (In years last birthday)<br><i>83</i>  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>at home</i>   |  | 11. BIRTHPLACE (State or foreign country)<br><i>Balti. Md.</i>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  |
| 13. FATHER'S NAME<br><i>Barnes</i>   |                         |   |  | 14. MOTHER'S MAIDEN NAME<br><i>Truff</i>   |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces?<br>(Yes, no or unknown) (If yes, give war or dates of service)<br><i>no</i>   |                         | 16. SOCIAL SECURITY NO.<br><i>217-09-5180</i>   |  | 17. INFORMANT<br><i>Thomas Truff</i>   |  | ADDRESS<br><i>788 Washington Blvd</i>   |  |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |                         |   |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><i>Myocardial Infarction Sudden</i><br><br>(B) <i>Arteriosclerotic Coronary Artery 7 years</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br><i>Dissect</i><br><br>(C) _____ |  |   |  |
| 19A. DATE OF OPERATION<br><i>0</i>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><i>no</i>   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)  |  |   |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?   |  |   |  |
| 22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>7/25</i> 19 <i>51</i> to <i>11/3</i> 19 <i>69</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>10/10</i> 19 <i>69</i> and that in <i>my</i> ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.   |                         |   |  |  |  |   |  |
| 23A. SIGNATURE<br><i>John P. Urlock Jr</i>   |                         |   |  | 23B. DATE SIGNED<br><i>11/3/69</i>   |  |   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><i>JOHN P. URLOCK JR</i>   |                         |   |  | 23D. ADDRESS<br><i>1227 Washington Blvd</i>  |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |                         | 24B. DATE<br><i>11/5/69</i>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><i>Green Haven Cemetery</i>  |  | 24D. LOCATION (City, town, or county) (State)<br><i>Greenland Ind.</i>                        |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>NOV 4 1969</i>   |                         | 25B. NAME OF REGISTRAR<br><i>Robert E. Galt</i>   |  | 25C. FUNERAL DIRECTOR<br><i>John J. Gorman &amp; Son Inc.</i>  |  | ADDRESS<br><i>23 Md.</i>  |  |





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                             |   |                                    |   |                        |  |                         |
|--|-----------------------------|---|------------------------------------|---|------------------------|--|-------------------------|
| O-650  |                             | 69 10816  |                                    | BALTIMORE CITY HEALTH DEPARTMENT  |                        | REG. NO. 69 10816  |                         |
| BIRTH NO.  |                             |   |                                    | 1. NAME OF DECEASED<br>(Type or Print) <u>CHARLES G. OREN</u>   |                        |  |                         |
| 2. DATE AND HOUR OF DEATH<br><u>10/31/69</u> <u>9 PM</u> M.  |                             |   |                                    | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                        |  |                         |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>UNION MEMORIAL HOSPITAL</u><br><u>BALTIMORE MD 21218</u>  |                             |   |                                    | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)<br>A. STATE <u>MD</u><br>B. COUNTY <u>1348</u> |                        |  |                         |
| C. CITY OR TOWN <u>BALTIMORE</u>   |                             |   |                                    | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |                        |  |                         |
| E. STREET AND NUMBER<br><u>1326 UNION AVE</u>  |                             |   |                                    |   |                        |  |                         |
| 5. SEX<br><u>MALE</u>  | 6. RACE<br><u>CAUCASIAN</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>9/26/91</u> | 9. AGE (in years lost birthday)<br><u>78</u>  | 10. Under 1 Yr. Months | 11. Under 24 Hrs. Days   | 12. Under 24 Hrs. Hours |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Ship Fitter (Retired)</u>  |                             |   |                                    | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Ship Yard (Bethlehem)</u>   |                        |  |                         |
| 11. BIRTHPLACE (State or foreign country)<br><u>MD.</u>  |                             |   |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |                        |  |                         |
| 13. FATHER'S NAME<br><u>?</u>  |                             |   |                                    | 14. MOTHER'S MAIDEN NAME<br><u>?</u>  |                        |  |                         |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>—</u>   |                             |   |                                    | 16. SOCIAL SECURITY NO.<br><u>—</u>   |                        |  |                         |
| 17. INFORMANT<br><u>Mary G. Scherer</u>  |                             |   |                                    | ADDRESS<br><u>3811 Rowenwood Ave</u>  |                        |  |                         |
| 18. <u>412.41</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><u>CAUSE OF DEATH</u><br><u>RESPIRATORY - ARREST</u><br><u>CEREBROVASCULAR ACCIDENT</u><br><u>ASCVD</u> |                             |   |                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                        |  |                         |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>II</u>  |                             |   |                                    |   |                        |  |                         |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |                             |   |                                    |   |                        |  |                         |
| 19A. DATE OF OPERATION<br><u>0</u>   |                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                    | 20A. AUTOPSY? (Yes or No)<br><u>N/O</u>   |                        | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                         |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                    | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |                        |  |                         |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |                             | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                                    | 21F. HOW DID INJURY OCCUR?  |                        |  |                         |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10/30</u> 19 <u>69</u> to <u>10/31</u> 19 <u>69</u> and that (my) (our) opinion death occurred on the date <u>10/31</u> 19 <u>69</u> and hour <u>9 PM</u> from the causes stated above. (I) (We) (did) (did not) view the body after death.               |                             |   |                                    |   |                        |  |                         |
| 23A. SIGNATURE<br><u>Ronald M. Legum M.D.</u>  |                             |   |                                    | 23B. DATE SIGNED<br><u>10/31/69</u>   |                        |  |                         |
| 23C. PHYSICIAN'S NAME (Type)<br><u>RONALD M. LEGUM M.D.</u>  |                             |   |                                    | 23D. ADDRESS<br><u>UNION MEMORIAL HOSPITAL BALT, MD.</u>  |                        |  |                         |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                             | 24B. DATE<br><u>11/3/69</u>   |                                    | 24C. NAME of CEMETERY or CREMATORY<br><u>Marlow Lodge</u>   |                        | 24D. LOCATION (City, town, or county) (State)<br><u>Harvey Ave.</u>  |                         |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 4 1969</u>   |                             | 25B. NAME OF REGISTRAR<br><u>Robert E. Taylor, M.D.</u>   |                                    | 25C. FUNERAL DIRECTOR<br><u>Paul E. Thompson</u>  |                        | ADDRESS<br><u>3615 Blount Ave</u>                                    |                         |

1944-1945  
1946-1947  
1948-1949  
1950-1951  
1952-1953

1954-1955  
1956-1957  
1958-1959  
1960-1961  
1962-1963

1964-1965  
1966-1967  
1968-1969  
1970-1971  
1972-1973

1974-1975

1976-1977  
1978-1979  
1980-1981  
1982-1983  
1984-1985

1986-1987  
1988-1989  
1990-1991  
1992-1993  
1994-1995

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |  | REG. NO. 69 10817  |  |
|--|--|--|--|
| E-325 69 10817   |  | CERTIFICATE OF DEATH   |  |
| BIRTH NO.  |  | 2. DATE AND HOUR OF DEATH  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Edson, George</u>  |  | 10-30-69 17:45 M.  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>BALTIMORE CITY HOSPITALS</u><br><u>4940 EASTERN AVE.</u>  |  | A. STATE <u>MARYLAND</u><br>B. COUNTY <u>1348</u>  |  |
| 31 <u>Baltimore, Md 21224</u>  |  | C. CITY OR TOWN <u>BALTIMORE</u><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 5. SEX <u>male</u>   |  | 6. RACE <u>white</u>   |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH <u>8-17-81</u>  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>water Dept.</u>   |  | 9. AGE (In years last birthday) <u>88</u>  |  |
| 10B. KIND OF BUSINESS OR INDUSTRY <u>Baltimore City</u>  |  | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>  |  |
| 13. FATHER'S NAME <u>ELI Edson</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 14. MOTHER'S MAIDEN NAME <u>Emma Collison</u>  |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>NO</u>  |  |
| 16. SOCIAL SECURITY NO. <u>218-52-0208</u>   |  | 17. INFORMANT <u>BCH RECORDS: BALTIMORE, MD. 21224</u>   |  |
| 18. <u>412.41</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>ASCVD</u><br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u> |  |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |  |  |  |
| 19A. DATE OF OPERATION <u>0</u>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20A. AUTOPSY? (Yes or No) <u>NO</u>  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                       |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |  |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>11-3-67</u> 19 <u>67</u> to <u>10-30</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>10-30</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |  |  |  |
| 23A. SIGNATURE <u>G.W. Gragg, M.D.</u>   |  | 23B. DATE SIGNED <u>10-30-69</u>   |  |
| 23C. PHYSICIAN'S NAME (Type) <u>G.W. GRAGG M.D.</u>  |  | 23D. ADDRESS <u>BALTIMORE, CITY HOSPITALS</u><br><u>4940 EASTERN AVE. BALTIMORE, MD. 21224</u>                                 |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 24B. DATE <u>11-3-69</u>   |  |
| 24C. NAME OF CEMETERY OR CREMATORY <u>St Marys Cemetery</u>  |  | 24D. LOCATION (City, town, or county) (State) <u>Laurel Md</u>   |  |
| 25A. DATE REC'D BY HEALTH DEPT. <u>NOV 4 1969</u>  |  | 25B. NAME OF REGISTRAR <u>Robert A. Fairbank</u>   |  |
| 25C. FUNERAL DIRECTOR <u>Frank J. Serty</u>  |  | ADDRESS <u>814 W 36 St Baltimore</u>   |  |

11/5/69 address 3544 Poole St. B6H, CT

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69 10818

BALTIMORE CITY HEALTH DEPARTMENT

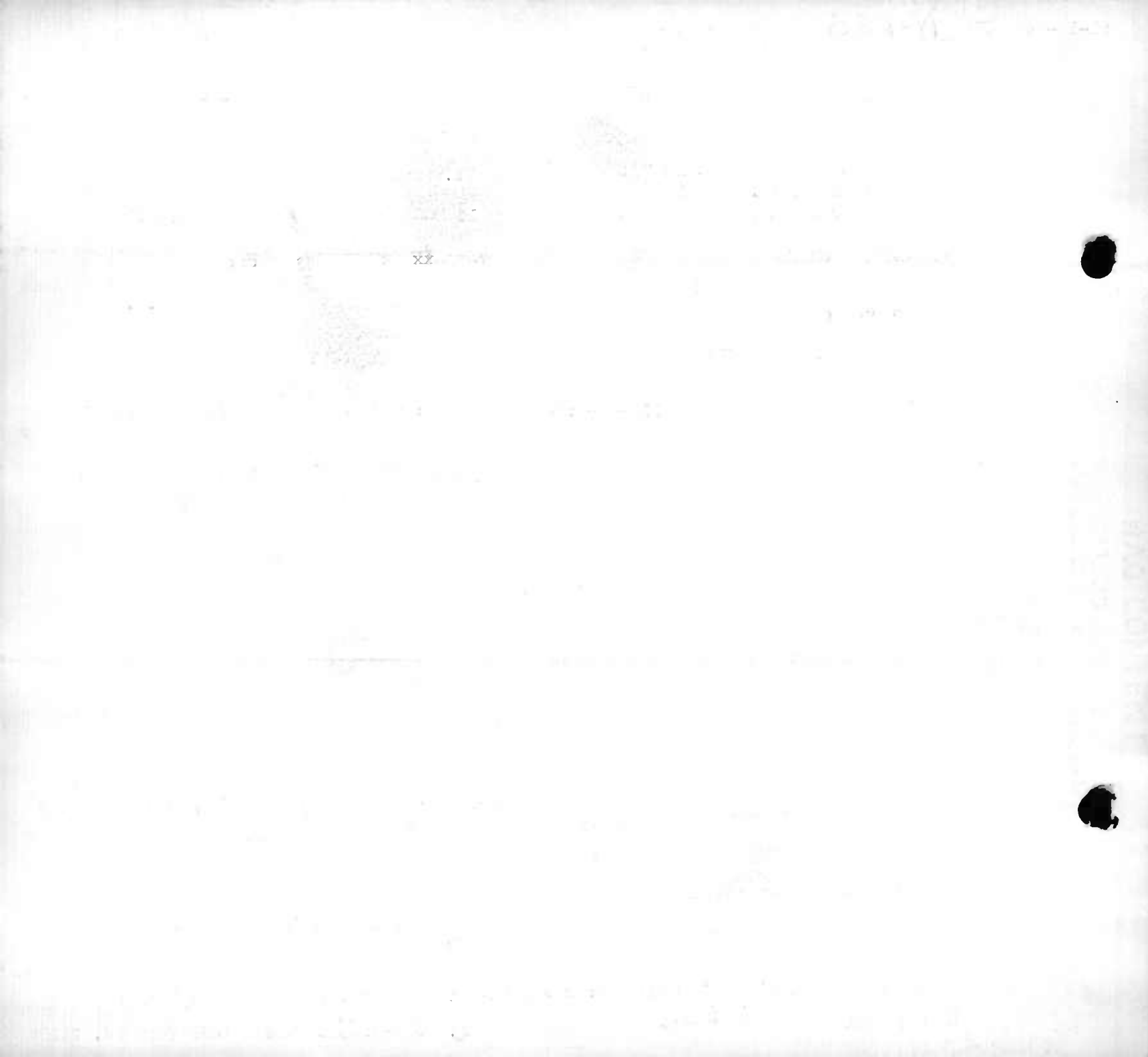
# CERTIFICATE OF DEATH

REG. NO. 69 10818

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |   |  |  |   |
|--|--|---|--|--|---|
| D-623  |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | X  |   |
| BIRTH NO. 69 10818   |  | CERTIFICATE OF DEATH  |  | REG. NO. 69 10818  |   |
| 1. NAME OF DECEASED<br>(Type or Print) <u>SARA H DUST</u>  |  |   | 2. DATE AND HOUR OF DEATH<br><u>2:45 AM 11-1-69</u>  |  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |   | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>BALTIMORE CITY HOSPITALS</u><br><u>4940 EASTERN AVENUE</u><br><u>BALTIMORE, MARYLAND #21224</u>  |  |   | C. CITY OR TOWN<br><u>Ft. Howard</u>   |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |
| 5. SEX <u>FEMALE</u>   |  |   | 6. RACE <u>WHITE</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |  |   | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><u>PENNSYLVANIA</u>  |
| 13. FATHER'S NAME<br><u>ALBERT Bard</u>  |  |   | 14. MOTHER'S MAIDEN NAME<br><u>MATILDA ?</u>   |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>  |  |   | 16. SOCIAL SECURITY NO.<br><u>188-12-5974</u>  |  | 17. INFORMANT <u>BALTIMORE CITY HOSPITALS</u> ADDRESS<br><u>RECORDS: 4940 EASTERN AVENUE #21224</u>   |
| 18. <u>412.4 I</u> CAUSE OF DEATH  |  |   |  |  |   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><u>ANTCEDENT CAUSES</u>  |  |   | (A) IMMEDIATE CAUSE <u>Atherosclerotic Cardiovascular</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br><u>Heart Disease</u>                         |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>5 1/2 hrs</u>  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  |   | (B) _____<br>DUE TO, OR AS A CONSEQUENCE OF:   |  |   |
| (C) _____  |  |   |  |  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |   |  |  |   |
| 19A. DATE OF OPERATION<br><u>2</u>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><u>YES</u>  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)          |   |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12-9</u> 19 <u>69</u> to <u>11-1</u> 19 <u>69</u><br>that (I) (we) last saw the deceased alive on <u>11-1</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |   |  |  |   |
| 23A. SIGNATURE<br><u>Arnold I. Levinson</u> M.D. DEGREE  |  |   |  | 23B. DATE SIGNED<br><u>12/1/69</u>   |   |
| 23C. PHYSICIAN'S NAME (Type)<br><u>ARNOLD I. LEVINSON</u> DEGREE   |  |   |  | 23D. ADDRESS<br><u>BALTIMORE CITY HOSPITALS</u><br><u>4940 EASTERN AVENUE #21224</u> |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 24B. DATE<br><u>11-4-1969</u>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><u>East Harrisburg Cemetery</u>                |   |
| 24D. LOCATION<br><u>Harrisburg, Pennsylvania</u>   |  | 24E. FUNERAL DIRECTOR<br><u>Wm. Cook Brooks</u> ADDRESS<br><u>Towson 1050 York Rd. 21204</u>              |  |  |   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |   |  |
|---|--|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. <span style="float: right;">69 10819</span>  |  |
| W-252 69 10819  |  | CERTIFICATE OF DEATH  |  |
| BIRTH NO.   |  | 1. NAME OF DECEASED (Type or Print) <u>Wojnowski CASIMER George</u>   |  |
| 2. DATE AND HOUR OF DEATH <u>11/1/69 1:05 pm</u>  |  | M.  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>North Charles Gen. Hosp.</u><br><u>N. Charles at 28th Balto.</u>  |  | A. STATE <u>Md</u> B. COUNTY <u>Balto</u>   |  |
| C. CITY OR TOWN <u>Balto</u>  |  | D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| E. STREET AND NUMBER <u>7918 Wise Ave</u>   |  |   |  |
| 5. SEX <u>M</u>   | 6. RACE <u>W</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   | 8. DATE OF BIRTH <u>6-16-15</u>                                      |
| WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. AGE (In years last birthday) <u>54</u>   | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.            |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>  |  | 10B. KIND OF BUSINESS OR INDUSTRY <u>TELEPHONE CO.</u>  | 11. BIRTHPLACE (City, State, or foreign country) <u>Md.</u>          |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |   |  |
| 13. FATHER'S NAME <u>Peter WOJNOWSKI</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Katherine?</u>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES WWII 1941-1945</u>  |  | 16. SOCIAL SECURITY NO. <u>213-01-4462</u>  | 17. INFORMANT <u>Hospital Chart</u>                                  |
| 18. <u>201X1</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <u>Massive exsanguination, probably intra-abdominal</u><br>(B) <u>Granulomatous infection -</u><br>(C) <u>Granuloma - Lymphoma</u> |  |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u>   |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |   |  |
| 19A. DATE OF OPERATION <u>0</u>   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20A. AUTOPSY? (Yes or No) <u>No</u>   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)   | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10-28-69</u> 19 to <u>11-1-69</u> 19, that (I) (we) last saw the deceased alive on <u>11-1-69</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                  |  |   |  |
| 23A. SIGNATURE <u>Juan Gan, M.D.</u>  |  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>   | 23B. DATE SIGNED <u>11-1-69</u>                                      |
| 23C. PHYSICIAN'S NAME (Type) <u>Juan GAN</u>  |  | 23D. ADDRESS <u>North Charles Gen. Hospital</u>   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  | 24B. DATE <u>11/5/69</u>   | 24C. NAME of CEMETERY or CREMATORY <u>Holy Rosary Cem.</u>  | 24D. LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>  |
| 25A. DATE REC'D BY HEALTH DEPT. <u>NOV 4 1969</u>   |  | 25B. NAME OF REGISTRAR <u>John E. J...</u>  | 25C. FUNERAL DIRECTOR <u>W. J. Flakowski</u>                         |
|   |  | ADDRESS <u>2007 Eastern Ave.</u>  |  |





# FUNERAL DIRECTOR: IMPORTANT

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| BALTIMORE CITY HEALTH DEPARTMENT   |                                |   |   | REG. NO. <b>69 10820</b>   |  |
|--|--------------------------------|---|---|--|--|
| <b>BIRTH NO.</b><br><b>H-425</b>   |                                | <b>69 10820 CERTIFICATE OF DEATH</b>  |   |  |  |
| <b>1. NAME OF DECEASED</b><br>(Type or Print) <b>PETER HOLZKNECHT, SR.</b>   |                                |   | <b>2. DATE AND HOUR OF DEATH</b><br><b>11-1-69 2:55 A.M.</b>  |  |  |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><br><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>THE JOHNS HOPKINS HOSPITAL</b><br><b>33 BALTIMORE, MD 21205</b>  |                                |   | <b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)<br><b>A. STATE</b> <b>MARYLAND</b><br><b>B. COUNTY</b> <b>703</b><br><b>C. CITY OR TOWN</b> <b>BALTIMORE</b><br><b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br><b>E. STREET AND NUMBER</b><br><b>716 N. COLLINGTON AVE</b> |  |  |
| <b>5. SEX</b><br><b>MALE</b>   | <b>6. RACE</b><br><b>WHITE</b> | <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> | <b>8. DATE OF BIRTH</b><br><b>4-30-1894</b>   | <b>9. AGE</b> (In years last birthday)<br><b>75</b>                              | <b>If Under 1 Yr. Months: Days:</b><br><b>If Under 24 Hrs. Hours: Min.</b> |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Furrier</b>   |                                | <b>10B. KIND OF BUSINESS OR INDUSTRY</b><br><b>Self Employed</b>  |   | <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>Austria</b>               |  |
| <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>U S A</b>  |                                |   | <b>13. FATHER'S NAME</b><br><b>Unknown</b>  |  |  |
| <b>14. MOTHER'S MAIDEN NAME</b><br><b>Unknown</b>  |                                |   | <b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |  |  |
| <b>16. SOCIAL SECURITY NO.</b><br><b>216-12-8013</b>   |                                | <b>17. INFORMANT</b><br><b>Tillie Makal Holzkmecht</b>  |   | <b>ADDRESS</b><br><b>Above</b>   |  |
| <b>18. CAUSE OF DEATH</b>  |                                |   |   |  |  |
| <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)<br><br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                                |   |   | <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b><br><b>3 hrs</b>              |  |
| <b>(A) IMMEDIATE CAUSE</b> <b>MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF:   |                                |   |   | <b>(B) CARDIAC ARREST ? PULMONARY EMBOLUS</b><br>DUE TO, OR AS A CONSEQUENCE OF: |  |
| <b>(C) DIABETES MELLITUS</b>   |                                |   |   | <b>DIABETES MELLITUS</b>   |  |
| <b>II</b>  |                                |   |   |  |  |
| <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b><br><b>DIABETES MELLITUS</b>  |                                |   |   |  |  |
| <b>19A. DATE OF OPERATION</b><br><b>2</b>  |                                | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>   |   | <b>20A. AUTOPSY? (Yes or No)</b><br><b>YES</b>                                   |  |
| <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>  |                                | <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>   |   |  |  |
| <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                | <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)   |   | <b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)                 |  |
| <b>21E. INJURY OCCURRED</b><br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                                | <b>21F. HOW DID INJURY OCCUR?</b>   |   |  |  |
| <b>22. I certify that (I) (this hospital) attended the deceased from 11/1/69 1969 to 11/1/19 1969, that (I) (we) last saw the deceased alive on 11/1 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>                            |                                |   |   |  |  |
| <b>23A. SIGNATURE</b><br><b>Harvey G. Klein</b>  |                                |   |   | <b>23B. DATE SIGNED</b><br><b>11/1/69</b>  |  |
| <b>23C. PHYSICIAN'S NAME (Type)</b><br><b>HARVEY G. KLEIN M.D.</b>   |                                |   |   | <b>23D. ADDRESS</b><br><b>THE JOHNS HOPKINS HOSPITAL</b>                         |  |
| <b>24A. BURIAL CREMATION, REMOVAL (Specify)</b><br><b>Burial</b>   |                                | <b>24B. DATE</b><br><b>11/4/69</b>  |   | <b>24C. NAME OF CEMETERY OR CREMATORY</b><br><b>Holy Redeemer Cemetery</b>       |  |
| <b>24D. LOCATION</b> (City, town, or county) (State)<br><b>Belair Rd. Baltimore, Md.</b>   |                                | <b>25A. DATE REC'D BY HEALTH DEPT.</b><br><b>NOV 4 1969</b>   |   |  |  |
| <b>25B. NAME OF REGISTRAR</b><br><b>John E. Kelly</b>  |                                | <b>25C. FUNERAL DIRECTOR</b><br><b>Schinner Funeral Home, 3331 Brehms Lane</b>  |   |  |  |

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**Figure 1**

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |         |  |   | REG. NO. <b>69 10821</b>   |   |
|--|---------|--|---|--|---|
| B-250  |         | 69 10821   |   | CERTIFICATE OF DEATH   |   |
| BIRTH NO.  |         | 1. NAME OF DECEASED<br>(Type or Print)   |   | 2. DATE AND HOUR OF DEATH  |   |
|  |         | CLARA MARY BOSSOM  |   | Oct. 30, 1969 8:20 A. M.   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |         |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)   |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><br>90 GOULD CONVALESARIUM  |         |  | A. STATE<br>Maryland, 21213   |  |   |
|  |         |  | B. COUNTY<br>Baltimore  |  |   |
|  |         |  | C. CITY OR TOWN   |  | D. INSIDE CITY LIMITS?  |
|  |         |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|  |         |  | E. STREET AND NUMBER<br>3107 Mareco Avenue  |  |   |
| 5. SEX   | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>               | 8. DATE OF BIRTH  | 9. AGE (In years last birthday)  | If Under 1 Yr. Months Days  |
| female   | white   | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>            | 12/1/1888   | 80   |   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |         | 10B. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)                                |   |
| Seamstress   |         | Lamb Bros.   |   | Baltimore, Maryland  |   |
| 13. FATHER'S NAME  |         |  | 14. MOTHER'S MAIDEN NAME  |  |   |
| James Diggs  |         |  | Catherine ?   |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |         | 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS  |   |
| No   |         | 219-20-9393-A  |   | James T. Kenny nephew 3107 Mareco Ave. 21213                             |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. |         |  | CAUSE OF DEATH<br><br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><i>Arteriosclerotic Cardiovascular Disease</i><br><br>(B) <i>Irreversible Cardiac Decompensation</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) _____ |  |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |         |  |   |  |   |
| 19A. DATE OF OPERATION   |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No)  |   |
|  |         |  |   |  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
|  |         |  |   |  |   |
| 21D. TIME OF INJURY (APPROX.)  |         | 21E. INJURY OCCURRED   |   | 21F. HOW DID INJURY OCCUR?   |   |
|  |         | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |   |  |   |
| 22. I certify that (I) (this hospital) attended the deceased from 9/23 1969 to Oct 30 1969, that (I) (we) last saw the deceased alive on 10/29 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                 |         |  |   |  |   |
| 23A. SIGNATURE   |         |  |   | 23B. DATE SIGNED   |   |
| Dr. L.B. Stevens   |         |  |   |  |   |
| 23C. PHYSICIAN'S NAME (Type)   |         | 23D. ADDRESS   |   |  |   |
| Dr. L.B. Stevens   |         | 3400 Erdman Avenue   |   |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |         | 24B. DATE  |   | 24C. NAME OF CEMETERY or CREMATORY                                       |   |
| Burial   |         | 11/1/1969  |   | Druid Ridge Cemetery   |   |
|  |         |  |   | Baltimore Maryland   |   |
| 25A. DATE REC'D BY HEALTH DEPT.  |         | 25B. NAME OF REGISTRAR   |   | 25C. FUNERAL DIRECTOR ADDRESS  |   |
| NOV 4 1969   |         | John A. ...  |   | Schinnerer Funeral Home, 3331 Brehms Lane                                |   |



69 10822 CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Vernon

2. DATE AND HOUR OF DEATH

10/30/69

235 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)BALTIMORE, CITY HOSPITALS  
4940 EASTERN AVE.  
BALTIMORE, MD. 212244. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)  
A. STATE B. COUNTY

MD.

Baltimore

5300

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

8322 Bletzer Rd. 21222

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

12-15-14

9. AGE (In years  
lost birthday)

54

If Under 1 Yr.  
Months DaysIf Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)Maintenance  
unemployed

10B. KIND OF BUSINESS OR INDUSTRY

Balto. County

11. BIRTHPLACE (State or foreign country)

MD. Baltimore

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

John Topper

14. MOTHER'S MAIDEN NAME

Ada Badger

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

215-14-4155

17. INFORMANT

4940 EASTERN AVE.

ADDRESS

BCH RECORDS BALTIMORE, MD. 21224

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, oshtenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Pulmonary Embolus

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Myelofibrosis

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

2 days

10 mos.

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Sepsis

6 hours

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐Not While ☐

At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10/4/69 19 69 to 10/30 19 69,  
that (I) (we) lost saw the deceased alive on 10/30 19 69 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

John A. Burton MD.

DEGREE

Attending ☐Med. ☐Staff ☒

23B. DATE SIGNED

30 Oct 69

23C. PHYSICIAN'S  
NAME (Type)

JOHN A. BURTON MD.

DEGREE

23D. ADDRESS

BALTIMORE CITY HOSPITALS

4940 EASTERN AVE. BALTIMORE, MD. 21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

11/3/69

24C. NAME OF CEMETERY or CREMATORY

Lorraine Park Cemetery

24D. LOCATION

Baltimore, Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 4 1969

25B. NAME OF REGISTRAR

Robert E. Taylor, MD.

25C. FUNERAL DIRECTOR

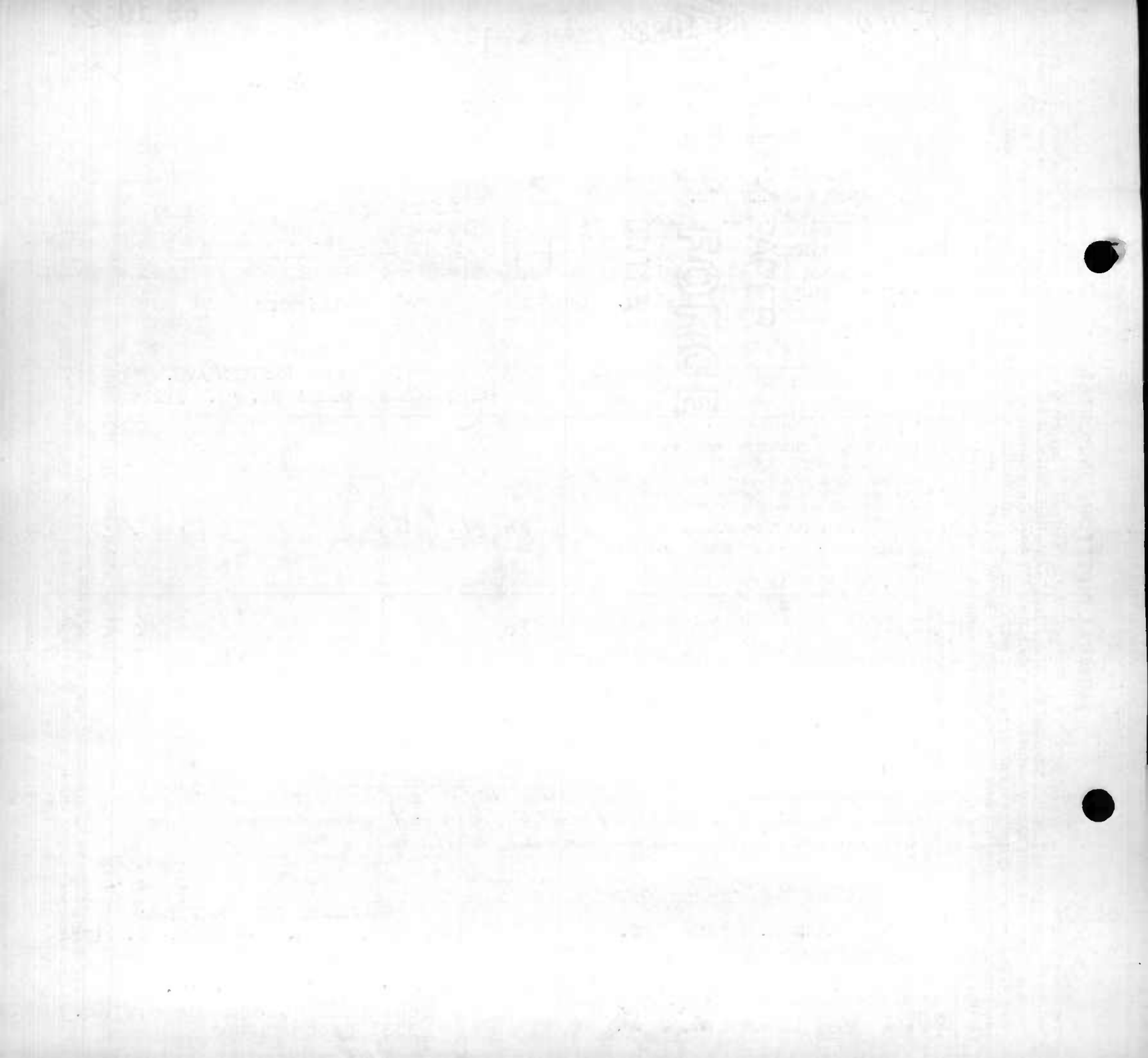
Schimunek Funeral Home, Inc.

3331 Brehms Lane

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

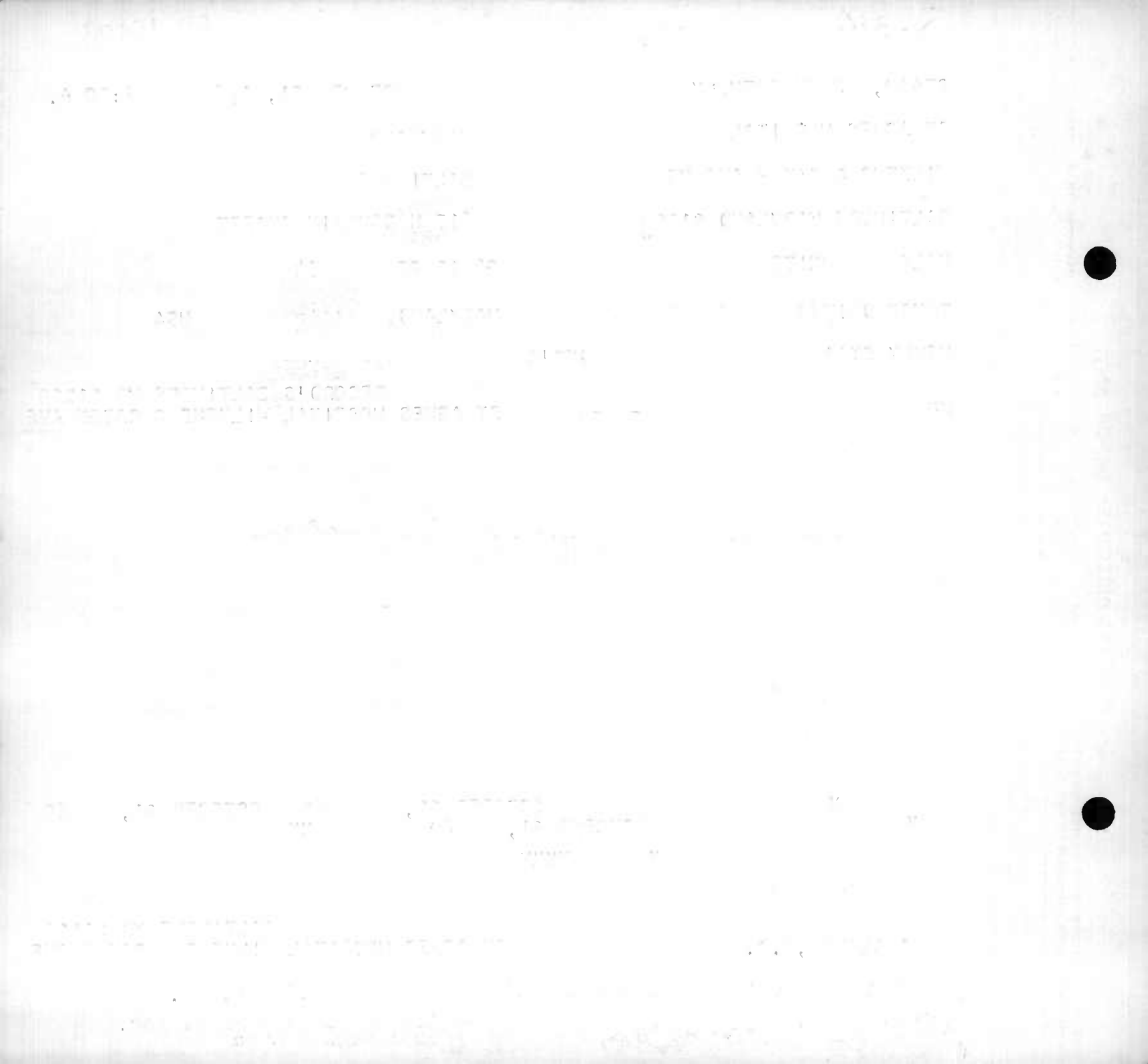
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                  |   |   |   |  |   |  |
|--|------------------|---|---|---|--|---|--|
| S-310  |                  | 69 10823  |   | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. 69 10823   |  |
| BIRTH NO.  |                  |   |   | 2. DATE AND HOUR OF DEATH   |  |   |  |
| 1. NAME OF DECEASED<br>(Type or Print)<br>STAAB, JOHN ANTHONY  |                  |   |   | OCTOBER 31, 1969   6:30 A. M.   |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>ST AGNES HOSPITAL<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>WILKENS & CATON AVENUE<br>BALTIMORE MARYLAND 21229   |                  |   |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE MARYLAND<br>B. COUNTY 2610<br>C. CITY OR TOWN BALTIMORE<br>D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER 617 N BOULDIN STREET |  |   |  |
| 5. SEX<br>MALE   | 6. RACE<br>WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>08 12 05                      | 9. AGE (In years last birthday)<br>64   | If Under 1 Yr. Months Days                                       | If Under 24 Hrs. Hours Min.   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>TRUCK DRIVER |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>TRUCK DRIVER  |                  |   | 10B. KIND OF BUSINESS OR INDUSTRY<br>Home Laundry |   | 11. BIRTHPLACE (State or foreign country)<br>MARYLAND, Baltimore |   | 12. CITIZEN OF WHAT COUNTRY?<br>USA  |
| 13. FATHER'S NAME<br>HENRY STAAB DEC 'D  |                  |   |   | 14. MOTHER'S MAIDEN NAME<br>Mary Meyers   |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO   |                  |   |   | 16. SOCIAL SECURITY NO.<br>212-10-8688  |  | 17. INFORMANT<br>RECORD'S BALTIMORE MD 21229<br>ST AGNES HOSPITAL WILKENS & CATON AVE |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>157.9 I<br>CA 9 jaundice<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>Cirrhotic Endotoxemia<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |                  |   |   | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 19A. DATE OF OPERATION   |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)   |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |   | 21F. HOW DID INJURY OCCUR?  |  |   |  |
| 22. I certify that (X) (this hospital) attended the deceased from OCTOBER 22, 19 69 to OCTOBER 31, 19 69 that (X) (we) last saw the deceased alive on OCTOBER 31, 19 69 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.  |                  |   |   |   |  |   |  |
| 23A. SIGNATURE<br><i>A. Alonso</i>   |                  |   |   | 23B. DATE SIGNED  |  |   |  |
| 23C. PHYSICIAN'S NAME (Type)<br>A ALONSO, M.D.   |                  |   |   | 23D. ADDRESS<br>BALTIMORE MD 21229<br>ST AGNES HOSPITAL WILKENS & CATON AVE   |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |                  | 24B. DATE<br>11/3/69  |   | 24C. NAME OF CEMETERY or CREMATORY<br>Gardens of Faith  |  | 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Md.                       |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 4 1969  |                  | 25B. NAME OF REGISTRAR<br>Robert E. Fisher, M.D.  |   | 25C. FUNERAL DIRECTOR<br>Schimmeler Funeral Home, Inc.<br>3331 Bröhm's Lane   |  | ADDRESS   |  |

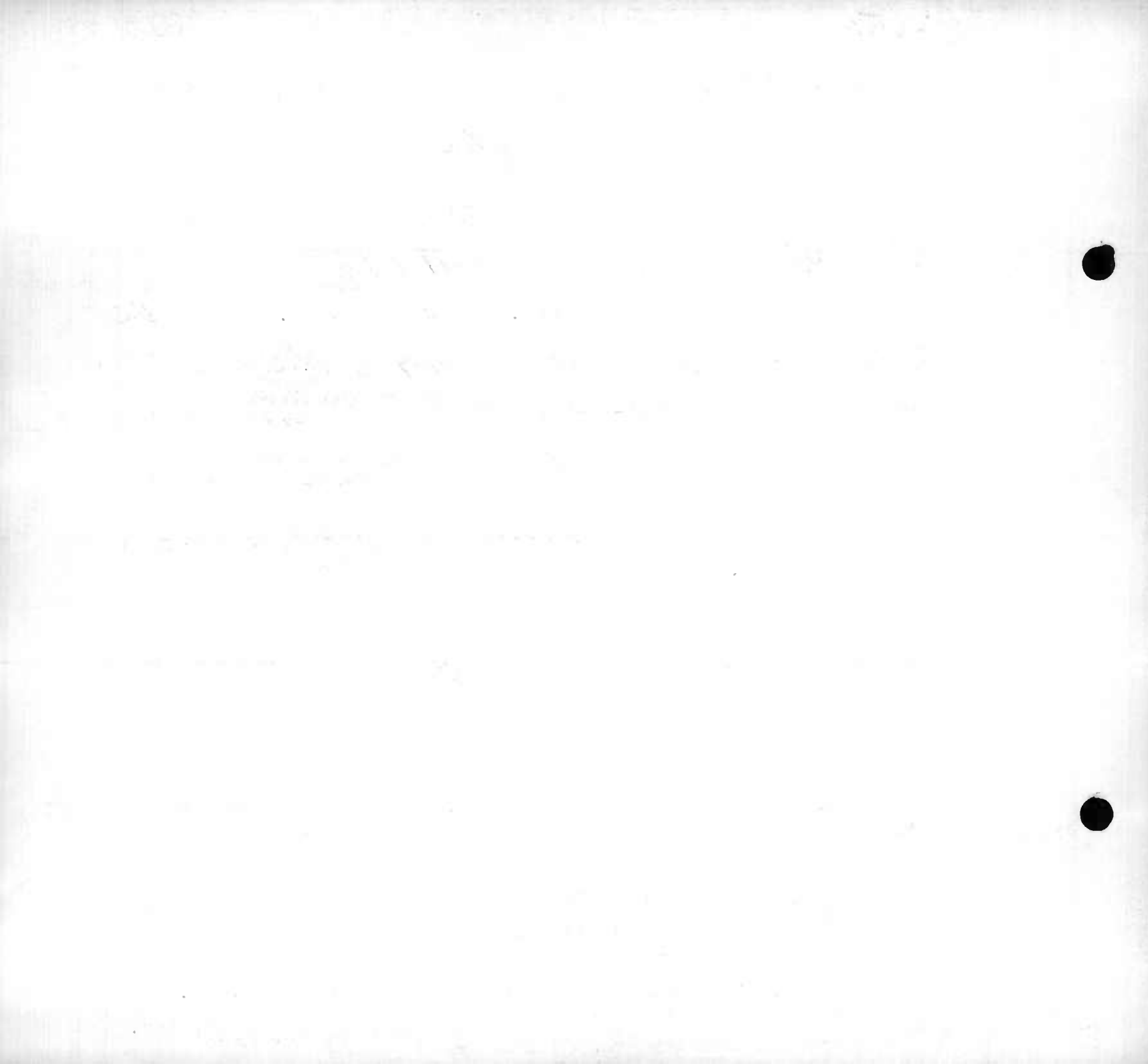




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

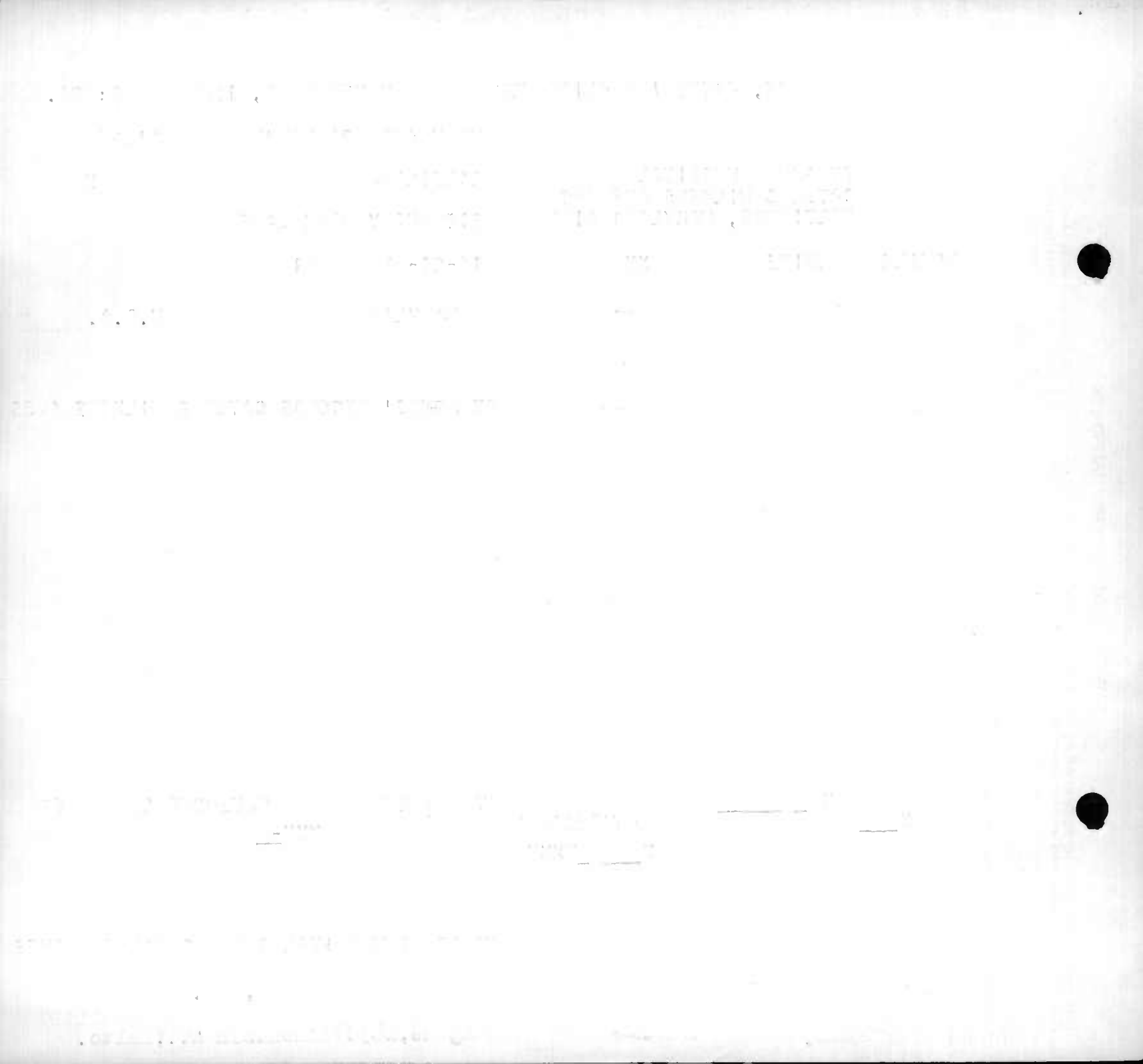
|  |                     |   |  |  |  |  |  |   |  |
|--|---------------------|---|--|--|--|--|--|---|--|
| C-656  |                     | 69 10824  |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | X  |  | 69 10824                                  |  |
| BIRTH NO.  |                     | 1. NAME OF DECEASED<br>(Type or Print) <b>John Arthur Cronhardt</b>   |  |  |  | 2. DATE AND HOUR OF DEATH<br><b>10-30-69 2:50 pm</b>   |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>38 UNIV. Hosp.</b>   |                     |   |  |  |  | 4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>CARROLL</b><br>C. CITY OR TOWN <b>5600</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>SPRINGFIELD STATE Hosp</b> |  |   |  |
| 5. SEX<br><b>M</b>   | 6. RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>1-11-04</b>                                       | 9. AGE (in years last birthday)<br><b>65</b> | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>   |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S</b> |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Clerk</b>  |                     |   |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Warrington Apts.</b>             |  | 13. FATHER'S NAME<br><b>ROYAL R. CRONHARDT</b>   |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>  |                     |   |  | 16. SOCIAL SECURITY NO.<br><b>215-09-6575</b>                            |  | 14. MOTHER'S MAIDEN NAME<br><b>MAY E. XXXXXXXX Nickel</b>  |  |   |  |
| 17. INFORMANT<br><b>ROBERT CRONHARDT son</b>   |                     |   |  | ADDRESS<br><b>2928 ST. PAUL ST.</b>                                      |  |  |  |   |  |
| 18. <b>199101</b>  |                     | CAUSE OF DEATH  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  |                     | (A) IMMEDIATE CAUSE<br><b>ANOXIA - SUPERIOR VENA CAVAL SYNDROME</b><br>DUE TO, OR AS A CONSEQUENCE OF:  |  |  |  |  |  |   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                     | (B) <b>METASTATIC UNDIFFERENTIATED CA.</b><br>DUE TO, OR AS A CONSEQUENCE OF:   |  |  |  |  |  |   |  |
| (C) _____  |                     |   |  |  |  |  |  |   |  |
| II   |                     |   |  |  |  |  |  |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                     |   |  |  |  |  |  |   |  |
| 19A. DATE OF OPERATION<br><b>0</b>   |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>  |  | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>                                   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |  |  |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?   |  |  |  |   |  |
| 22. I certify that (X) (this hospital) attended the deceased from <b>10-22</b> 19 <b>69</b> to <b>10-30</b> 19 <b>69</b> that (X) (we) last saw the deceased alive on <b>10-30</b> 19 <b>69</b> and that in (we) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                     |   |  |  |  |  |  |   |  |
| 23A. SIGNATURE<br><b>Gary L. Nobel</b>   |                     |   |  |  |  | 23B. DATE SIGNED<br><b>10-30-69</b>  |  |   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>GARY L. NOBEL MD</b>  |                     | 23D. ADDRESS<br><b>Univ. Hosp</b>   |  |  |  |  |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                     | 24B. DATE<br><b>11/3/69</b>   |  | 24C. NAME of CEMETERY or CREMATORY<br><b>Parkwood Cemetery</b>           |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>   |  |   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 4 1969</b>   |                     | 25B. NAME OF REGISTRAR<br><b>26.64 26.64</b>  |  | 25C. FUNERAL DIRECTOR<br><b>Schimmek Funeral Home, Inc.</b>              |  | ADDRESS<br><b>8838 Brehms Lane</b>   |  |   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| B-200 69 10825 BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH  |                  |   |   | REG. NO. 69 10825  |   |
|--|------------------|---|---|--|---|
| BIRTH NO.  |                  | 1. NAME OF DECEASED<br>(Type or Print)  |   | 2. DATE AND HOUR OF DEATH  |   |
|  |                  | BACH, KATHERINE ELIZABETH   |   | NOVEMBER 2, 1969 3:00A. M.   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                  |   | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><br>40 ST AGNES HOSPITAL<br>CATON & WILKENS AVENUES<br>BALTIMORE, MARYLAND 21229   |                  |   | A. STATE & COUNTY<br>MARYLAND BALTIMORE 21228 5300                                    |  |   |
|  |                  |   | C. CITY OR TOWN<br>BALTIMORE  |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|  |                  |   | E. STREET AND NUMBER<br>315 SHADY NOOK LANE   |  |   |
| 5. SEX<br>FEMALE   | 6. RACE<br>WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>12-21-87  | 9. AGE (In years last birthday)<br>81                                    | If Under 1 Yr. Months: Days: Hours: Min.  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife   |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>--   | 11. BIRTHPLACE (State or foreign country)<br>MARYLAND                                 |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |
| 13. FATHER'S NAME<br>? Wilson  |                  |   | 14. MOTHER'S MAIDEN NAME<br>?   |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO   |                  | 16. SOCIAL SECURITY NO.<br>--   |   | 17. INFORMANT ADDRESS<br>ST AGNES' RECORDS CATON & WILKENS AVES          |   |
| 18. CAUSE OF DEATH   |                  |   |   |  |   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                  |   |   |  |   |
| 19A. DATE OF OPERATION<br>10   |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)<br>NO  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |   | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (X) (this hospital) attended the deceased from OCTOBER 28 19 69 to NOVEMBER 2 19 69 that (X) (we) last saw the deceased alive on NOVEMBER 2 19 69 and that in (XXX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXX) view the body after death.           |                  |   |   |  |   |
| 23A. SIGNATURE<br>Chawenz Ongkasuwana, M.D.  |                  |   |   | 23B. DATE SIGNED<br>11-2-69  |   |
| 23C. PHYSICIAN'S NAME (Type)<br>CHAWENZ ONGKASUWAN, M.D.   |                  |   |   | 23D. ADDRESS<br>ST AGNES HOSPITAL CATON & WILKENS AVES                   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |                  | 24B. DATE   |   | 24C. NAME OF CEMETERY or CREMATORY                                       |   |
| Burial   |                  | 11/5/69   |   | Loudon Park  |   |
| 24D. LOCATION (City, town, or county) (State)  |                  | 24E. DATE REC'D BY HEALTH DEPT.   |   |  |   |
| Baltimore, Md.   |                  | NOV 4 1969  |   |  |   |
| 25A. NAME OF REGISTRAR   |                  | 25B. FUNERAL DIRECTOR   |   | 25C. ADDRESS   |   |
| Robert E. Taylor   |                  | Wigzka, 1530  |   | Edmondson Av., Balto.  |   |



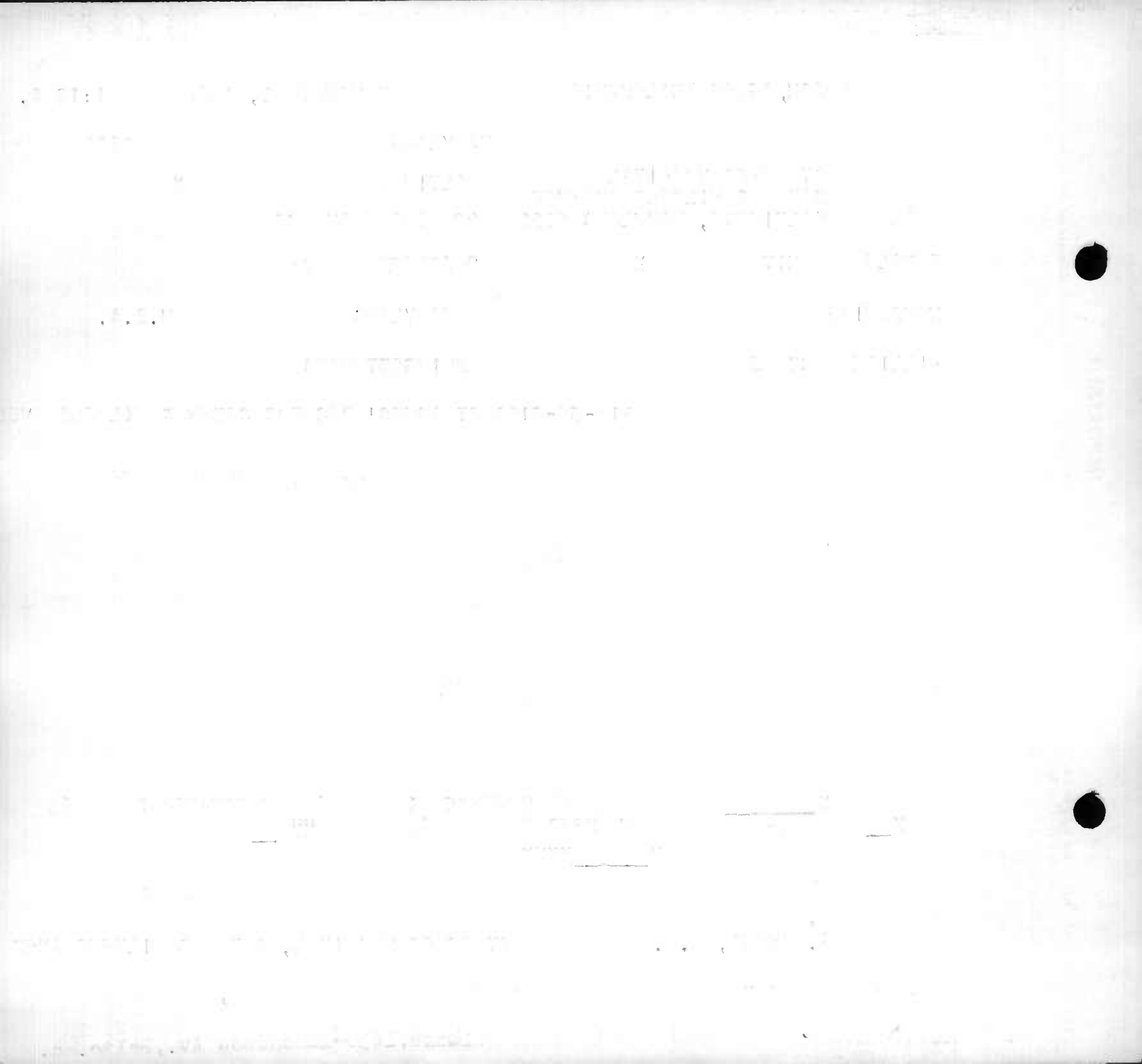
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                     |   |  |   |  |
|--|---------------------|---|--|---|--|
| T-632 69 10826   |                     | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. 69 10826   |  |
| <b>CERTIFICATE OF DEATH</b>  |                     |   |  |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>TWARDOWICZ, EUGENE J.</u>  |                     | 2. DATE AND HOUR OF DEATH<br><u>11-2-69 5:30 P.M.</u>   |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><u>Bon Secours Hospital</u>  |                     | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <u>Md.</u> B. COUNTY <u>2834</u>                          |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>Bon Secours Hospital</u>   |                     | C. CITY OR TOWN<br><u>Baltimore</u>   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
|  |                     | E. STREET AND NUMBER<br><u>1009 Wedgewood Road</u>  |  |   |  |
| 5. SEX<br><u>M</u>   | 6. RACE<br><u>C</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>10-6-08</u>  | 9. AGE (In years last birthday)<br><u>61</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Athletic Director</u>  |                     | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Red Shield Boys Club</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |
| 13. FATHER'S NAME<br><u>Pete Twardowicz</u>  |                     | 14. MOTHER'S MAIDEN NAME<br><u>Tomowski Valerie</u>   |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>no</u>  |                     | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS<br><u>Mrs. Eugene J. Twardowicz, 1009 Wedgewood Rd</u>                  |  |
| 18. CAUSE OF DEATH   |                     |   |  |   |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><u>410.9 I</u>   |                     |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 days</u>                                 |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>II</u>  |                     |   |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><u>Acute myocardial infarction</u>     |  |
|  |                     |   |  | (B) <u>Coronary arteriosclerosis w. occlusion</u> years                                       |  |
|  |                     |   |  | (C) <u>Arteriosclerotic heart disease</u> years   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |                     |   |  |   |  |
| 19A. DATE OF OPERATION<br><u>2</u>   |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><u>Yes</u>   |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)  |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that <u>41</u> (this hospital) attended the deceased from <u>10-31</u> 19 <u>67</u> to <u>11-2</u> 19 <u>69</u> that <u>41</u> (we) last saw the deceased alive on <u>11-12</u> 19 <u>69</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>41</u> (We) (did) (did not) view the body after death. |                     |   |  |   |  |
| 23A. SIGNATURE<br><u>M. Abbas M.D.</u>   |                     |   |  | 23B. DATE SIGNED<br><u>11-2-69</u>  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>Mahmoud Abbas M.D.</u>  |                     |   |  | 23D. ADDRESS<br><u>Bon Secours Hosp.</u>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                     | 24B. DATE<br><u>11/6/69</u>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><u>Lorraine Park Cemetery</u>                           |  |
|  |                     |   |  | 24D. LOCATION (City, town, or county) (State)<br><u>Baltimore, Md.</u>                        |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 4 1969</u>   |                     | 25B. NAME OF REGISTRAR<br><u>Robert E. Sabely M.D.</u>  |  | 25C. FUNERAL DIRECTOR ADDRESS<br><u>Stzke, 1630 Edmondson Ave., Catonsville</u>               |  |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO.   |  | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH  |  | REG. NO. 69 10827   |  |
|---|--|---|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print)  |  | ROACH, AGNES PHILOMENIA   |  | 2. DATE AND HOUR OF DEATH<br>NOVEMBER 2, 1969 1:15 A.M.                                       |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE B. COUNTY                                       |  | MARYLAND 21229  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>40  |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>ST AGNES HOSPITAL<br>CATON & WILKENS AVENUES<br>BALTIMORE, MARYLAND 21229 |  | C. CITY OR TOWN<br>BALTIMORE  |  |
| 5. SEX<br>FEMALE  |  | 6. RACE<br>WHITE  |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH<br>08/22/07  |  | 9. AGE (in years last birthday)<br>62   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>HOUSEWIFE  |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br>MARYLAND   |  |
| 13. FATHER'S NAME<br>WILLIAM P BYRNE  |  | 14. MOTHER'S MAIDEN NAME<br>BRIDGETT WARD   |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO  |  | 16. SOCIAL SECURITY NO.<br>219-50-5123  |  | 17. INFORMANT<br>ST AGNES' RECORDS CATON & WILKENS AVES                                       |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>430.9 I<br>I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>Subarachnoid Hemorrhage   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 19A. DATE OF OPERATION  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br>NO   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (X) (this hospital) attended the deceased from NOVEMBER 1 1969 to NOVEMBER 2 1969 that (X) (we) lost saw the deceased alive on NOVEMBER 2 1969 and that (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (X) (X) view the body after death.  |  |   |  |   |  |
| 23A. SIGNATURE<br>A. Shams, M.D.  |  | 23B. DATE SIGNED<br>11-2-69   |  | 23C. PHYSICIAN'S NAME (Type)<br>A. SHAMS, M.D.  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |  | 24B. DATE<br>11-5-69  |  | 24C. NAME OF CEMETERY or CREMATORY<br>New Cathedral Cemetery                                  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 4 1969   |  | 25B. NAME OF REGISTRAR<br>Robert E. Taylor, M.D.  |  | 25C. FUNERAL DIRECTOR<br>Wibzke, 1630 Edmondson Av., Balto. Md.                               |  |
| 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Maryland  |  | 24E. ADDRESS<br>ST AGNES HOSPITAL, CATON & WILKENS AVES   |  | 24F. ADDRESS<br>21228   |  |





# FUNERAL DIRECTOR: IMPORTANT

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|   |  |          |  |  |  |                   |  |
|---|--|----------|--|--|--|-------------------|--|
| K-242   |  | 69 10828 |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | REG. NO. 69 10828 |  |
| BIRTH NO.   |  |          |  | 1. NAME OF DECEASED<br>(Type or Print) <b>Joseph J. Kosloski</b>   |  |                   |  |
| 2. DATE AND HOUR OF DEATH<br><b>Nov. 2, 1969</b>  |  |          |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |                   |  |
| 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>2864</b>  |  |          |  | 5. FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Lutheran Hospital</b>                  |  |                   |  |
| 6. CITY OR TOWN<br><b>Baltimore</b>   |  |          |  | 7. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |                   |  |
| 8. STREET AND NUMBER<br><b>4502 Old Frederick Road</b>  |  |          |  | 9. SEX <b>M</b>  |  |                   |  |
| 10. RACE <b>W</b>   |  |          |  | 11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                   |  |
| 12. DATE OF BIRTH<br><b>Feb. 7, 1901</b>  |  |          |  | 13. AGE (in years last birthday) <b>68</b><br>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.  |  |                   |  |
| 14. BIRTHPLACE (State or foreign country)<br><b>Pennsylvania</b>  |  |          |  | 15. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |                   |  |
| 16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>  |  |          |  | 17. KIND OF BUSINESS OR INDUSTRY<br><b>Western Elec. Co.</b>   |  |                   |  |
| 18. FATHER'S NAME<br><b>John Kosloski</b>   |  |          |  | 19. MOTHER'S MAIDEN NAME<br><b>Sophie Sawicka</b>  |  |                   |  |
| 20. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year of entry and date of service)<br><b>Yes WWI 4-29-18 11-15-19</b>   |  |          |  | 21. SOCIAL SECURITY NO.<br><b>216-03-5657</b>  |  |                   |  |
| 22. INFORMANT<br><b>Mrs. Jos. J. Kosloski</b>   |  |          |  | 23. ADDRESS<br><b>Balto. 21229 4502 Old Fred. Rd.</b>  |  |                   |  |
| 24. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>acute coronary thrombosis, senile</b>  |  |          |  | 25. CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>Diabetes</b>   |  |                   |  |
| 26. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b>   |  |          |  | 27. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                         |  |                   |  |
| 28. MEDICAL CERTIFICATION<br>19A. DATE OF OPERATION<br><b>0</b>   |  |          |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |                   |  |
| 29. 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |  |          |  | 20A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  |                   |  |
| 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |  |          |  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)  |  |                   |  |
| 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  |          |  | 21F. HOW DID INJURY OCCUR?   |  |                   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>1-10-66</b> 19 to <b>11-2-69</b> 19<br>that (I) (we) last saw the deceased alive on <b>9-11-69</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the cause(s) stated above. (I) (We) (did) (did not) view the body after death. |  |          |  |  |  |                   |  |
| 23A. SIGNATURE<br><b>Harry S. Gimble</b>  |  |          |  | 23B. DATE SIGNED<br><b>11-3-69</b>   |  |                   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Harry S. Gimble</b>  |  |          |  | 23D. ADDRESS<br><b>4605 Edmondson Av., Balto., Md. 21229</b>   |  |                   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |          |  | 24B. DATE<br><b>11-5-69</b>  |  |                   |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>New Cathedral Cemetery Baltimore National</b>  |  |          |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>  |  |                   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 4 1969</b>  |  |          |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Witzke</b>  |  |                   |  |
| 25C. FUNERAL DIRECTOR<br><b>Witzke, 41013 Edmondson Av., Balto., Md</b>   |  |          |  | 25D. ADDRESS<br><b>21229</b>   |  |                   |  |

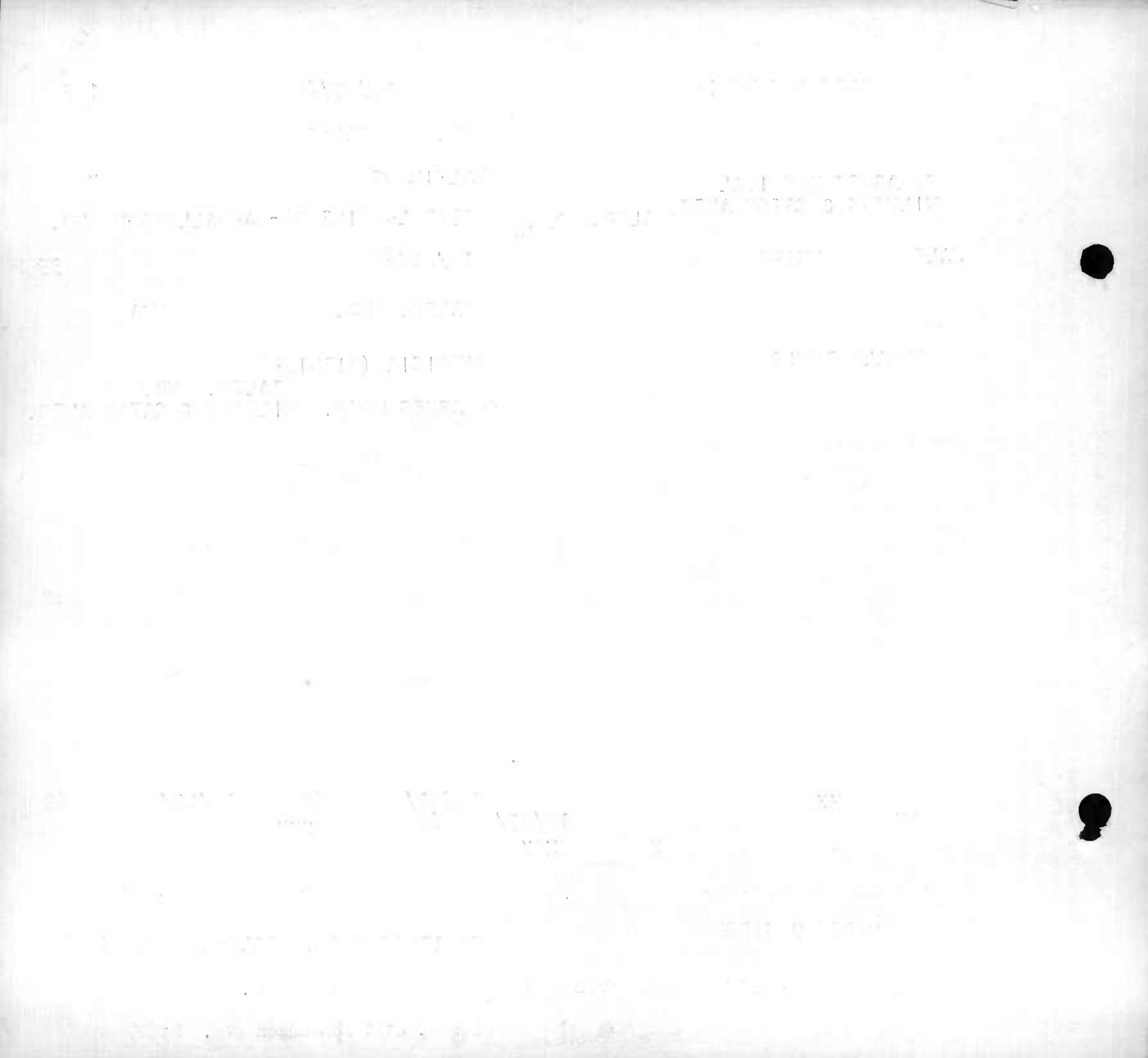
11/7/69 - Correction form from funeral director.

*Age.*

# FUNERAL DIRECTOR: IMPORTANT

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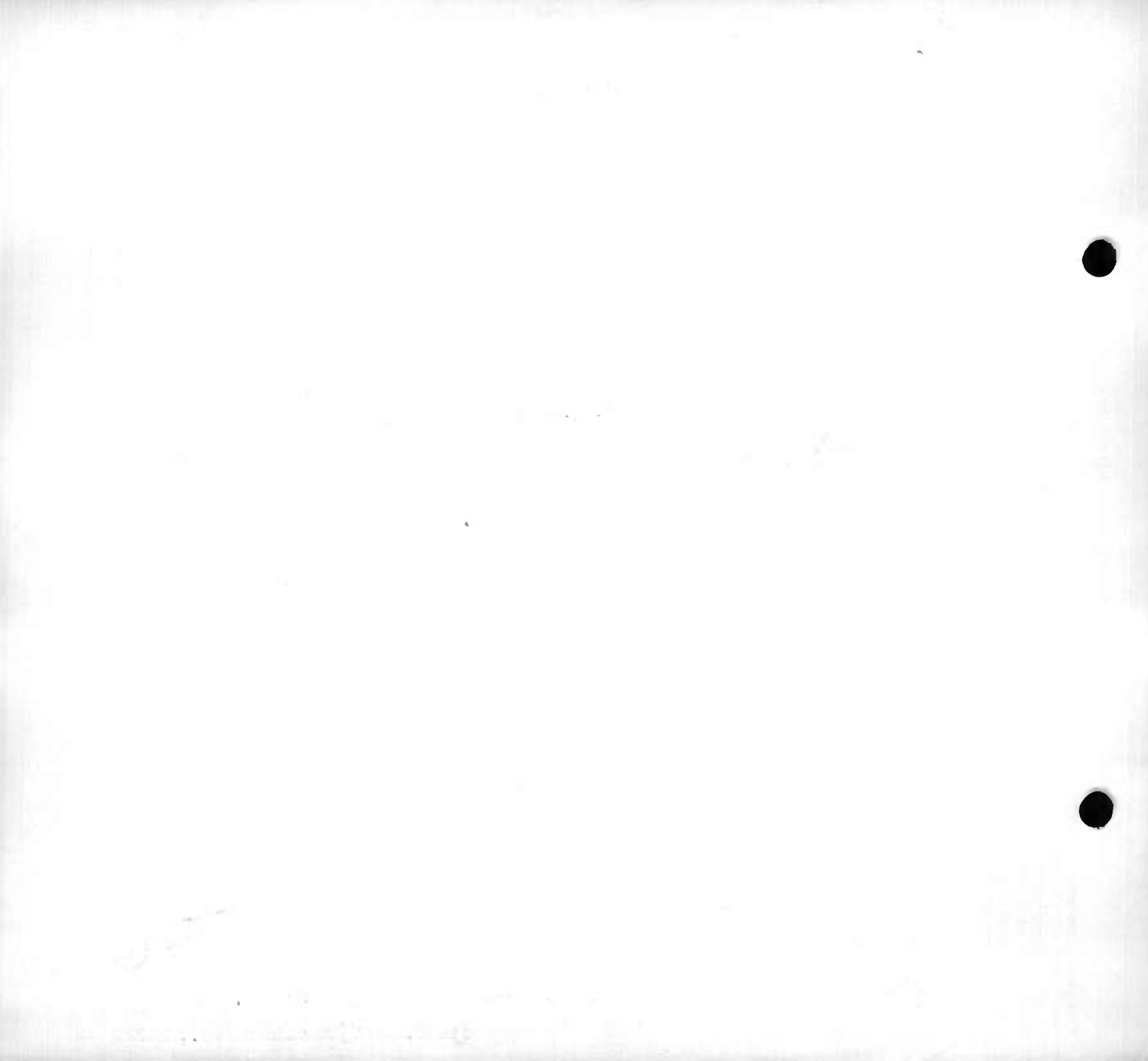
|  |                  |   |   |   |  |
|--|------------------|---|---|---|--|
| B-000<br>BIRTH NO. 69-1949569 10829  |                  | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH  |   | X REG. NO. 69 10829                                       |  |
| 1. NAME OF DECEASED<br>(Type or Print)<br>BABY BOY BOWIE   |                  |   | 2. DATE AND HOUR OF DEATH<br>10/27/69 1 P M.  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>ST AGNES HOSPITAL<br>WILKENS & CATON AVES. BALTO., MD.  |                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission)<br>A. STATE MD. B. COUNTY BALTO<br>C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>E. STREET AND NUMBER 3722 LAMOINE RD-RANDALLSTOWN, MD. |   |  |
| 5. SEX<br>MALE   | 6. RACE<br>WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>10/27/69  | 9. AGE (In years last birthday)                           | If Under 1 Yr. Months Days If Under 24 Hrs. Min. 35 M    |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                  |   | 10B. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country)<br>BALTO., MD. |
| 12. CITIZEN OF WHAT COUNTRY?<br>USA  |                  |   | 13. FATHER'S NAME<br>DONALD BOWIE   |   |  |
| 14. MOTHER'S MAIDEN NAME<br>PATRICIA (BIENIEK)   |                  |   | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |   |  |
| 16. SOCIAL SECURITY NO.  |                  |   | 17. INFORMANT<br>BALTO., MD.<br>ST AGNES HOSP., WILKENS & CATON AVES.   |   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |                  |   | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>Immaturity<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) Premature rupture of membrane<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) Infection   |   |  |
| 19A. DATE OF OPERATION   |                  |   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |
| 20A. AUTOPSY? (Yes or No)<br>NO  |                  |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                  |   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                  |   | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |   |  |
| 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                  |   | 21F. HOW DID INJURY OCCUR?  |   |  |
| 22. I certify that (this hospital) attended the deceased from 10/27/1969 to 10/27/1969 that (we) lost saw the deceased alive on 10/27/1969 and that (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.  |                  |   |   |   |  |
| 23A. SIGNATURE<br>Maria D. Giron   |                  |   | 23B. DATE SIGNED<br>10 27 69  |   |  |
| 23C. PHYSICIAN'S NAME (Type)<br>MARIA D GIRON  |                  |   | 23D. ADDRESS<br>ST AGNES HOSP. BALTO., MD. 21228  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial   |                  | 24B. DATE<br>10/31/69   |   | 24C. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Cemetery |  |
| 24D. LOCATION (City, town, or county)<br>Baltimore, Md.  |                  | 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 4 1969   |   |   |  |
| 25B. NAME OF REGISTRAR<br>John E. Taylor, M.D.   |                  | 25C. FUNERAL DIRECTOR<br>Witaker 4101 Edmondson Ave. 21229  |   |   |  |



# FUNERAL DIRECTOR: IMPORTANT

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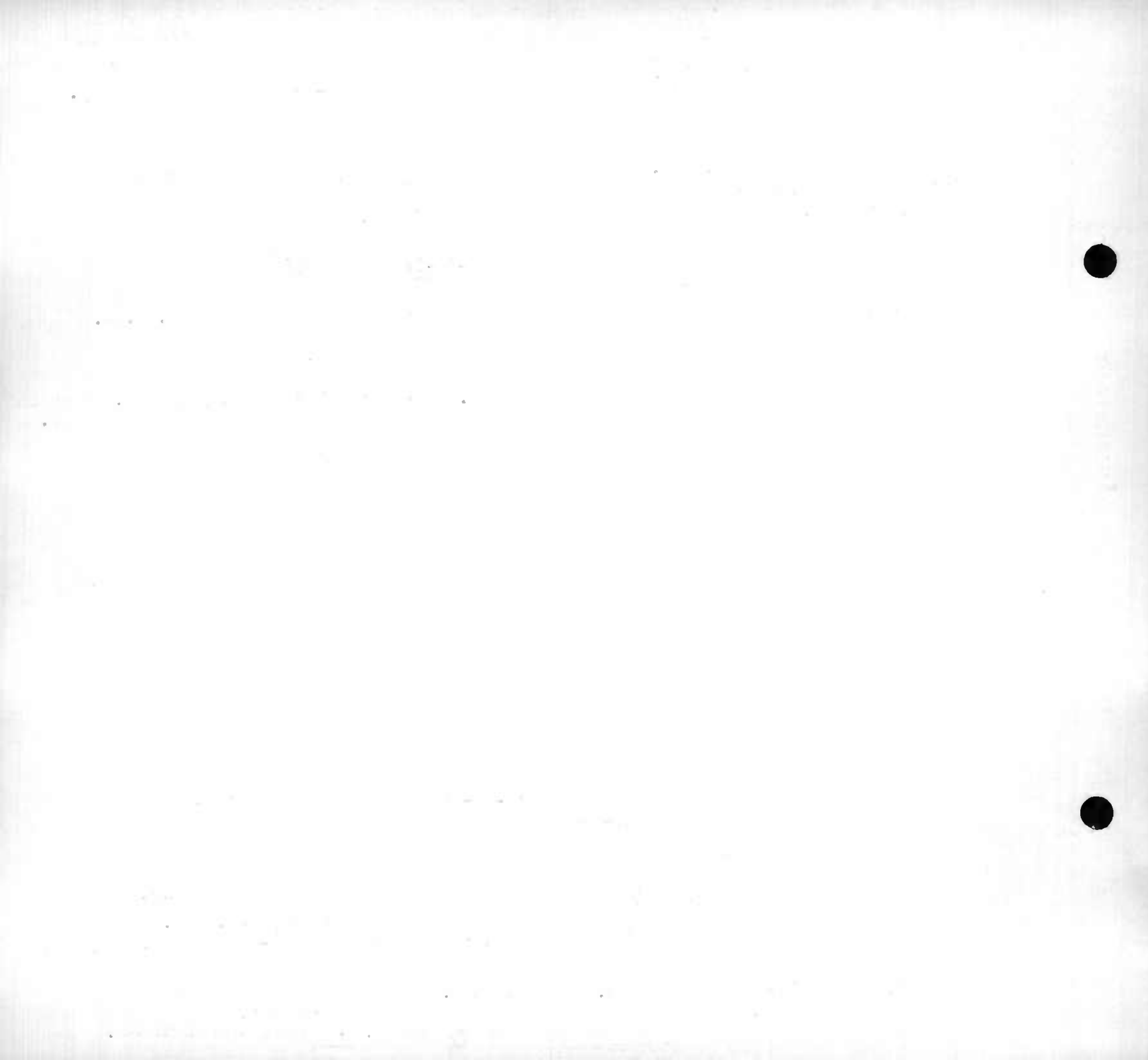
|  |                  |   |                              |  |                             |   |                              |
|--|------------------|---|------------------------------|--|-----------------------------|---|------------------------------|
| R-340  |                  | 69 10830  |                              | BALTIMORE CITY HEALTH DEPARTMENT   |                             | REG. NO. 69 10830   |                              |
| BIRTH NO.  |                  |   |                              | CERTIFICATE OF DEATH   |                             |   |                              |
| 1. NAME OF DECEASED<br>(Type or Print)   |                  |   |                              | 2. DATE AND HOUR OF DEATH  |                             |   |                              |
| VIOLEA RIDDLE  |                  |   |                              | 2-10 P.M. 110-28-69 M.   |                             |   |                              |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                  |   |                              | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  |                             |   |                              |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>36 FRANKLIN SQUARE HOSPITAL  |                  |   |                              | A. STATE B. COUNTY<br>Maryland Baltimore   |                             |   |                              |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |                  |   |                              | C. CITY OR TOWN<br>Baltimore   |                             | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                              |
|  |                  |   |                              | E. STREET AND NUMBER<br>1427 W. Baltimore St   |                             |   |                              |
| 5. SEX<br>Female   | 6. RACE<br>White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>01/09/20 | 9. AGE (In years last birthday)<br>49 yrs  | 10. Under 1 Yr. Months Days |   | 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>unemployed  |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>—  |                              | 11. BIRTHPLACE (State or foreign country)<br>Maryland  |                             | 12. CITIZEN OF WHAT COUNTRY?<br>America   |                              |
| 13. FATHER'S NAME<br>WILLIAM EDWARD SMITH  |                  |   |                              | 14. MOTHER'S MAIDEN NAME<br>GRACE JOHNSON  |                             |   |                              |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |                  | 16. SOCIAL SECURITY NO.<br>214-18-0792  |                              | 17. INFORMANT ADDRESS  |                             |   |                              |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |                  |   |                              | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>RLL LUNG ABSCESS<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>congestive cardiac failure<br>(C) DUE TO, OR AS A CONSEQUENCE OF:<br>+ Pulmonary Infarction |                             |   |                              |
| 19A. DATE OF OPERATION<br>0  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                              | 20A. AUTOPSY? (Yes or No)  |                             | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |                              |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                              | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                             |   |                              |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                              | 21F. HOW DID INJURY OCCUR?   |                             |   |                              |
| 22. I certify that (I) (this hospital) attended the deceased from 9:20 19 69 to 10:28 19 69 that (I) (we) last saw the deceased alive on 10-28-19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                  |   |                              |  |                             |   |                              |
| 23A. SIGNATURE<br>ANIS Fatima SIDDIQI  |                  |   |                              | 23B. DATE SIGNED   |                             |   |                              |
| 23C. PHYSICIAN'S NAME (Type)   |                  |   |                              | 23D. ADDRESS   |                             |   |                              |
| M.D. FRANKLIN SQUARE HOSPITAL  |                  |   |                              |  |                             |   |                              |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |                  | 24B. DATE   |                              | 24C. NAME of CEMETERY or CREMATORY   |                             | 24D. LOCATION (City, town, or county) (State)   |                              |
| Burial   |                  | 11/3/69   |                              | Baltimore National Cemetery  |                             | Baltimore, Md.  |                              |
| 25A. DATE REC'D BY HEALTH DEPT.  |                  | 25B. NAME OF REGISTRAR  |                              | 25C. FUNERAL DIRECTOR  |                             | ADDRESS   |                              |
| NOV 4 1969   |                  | J. Edgar  |                              | Witzke   |                             | 4101 Edmondson Ave., 21229  |                              |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |  |  |  | 69 10831   |  | 69 10831   |  |                 |  |
|---|--|--|--|--|--|--|--|-----------------|--|
| <b>BIRTH NO.</b><br><div style="font-size: 2em; float: left; margin-right: 10px;">R-300</div> <div style="font-size: 2em; float: left; margin-right: 10px;">69 10831</div> <div style="clear: both;"></div>   |  |  |  | <b>CERTIFICATE OF DEATH</b>  |  |  |  | <b>REG. NO.</b> |  |
| <b>1. NAME OF DECEASED</b><br><small>(Type or Print)</small><br><div style="text-align: center;">(Edward)<br/>William Rudd</div>  |  |  |  | <b>2. DATE AND HOUR OF DEATH</b><br><div style="display: flex; justify-content: space-between;"> <div>11-2-69</div> <div>8:05 p. M.</div> </div>   |  |  |  |                 |  |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><div style="display: flex; justify-content: space-between;"> <div> <b>FULL NAME OF HOSPITAL OR INSTITUTION</b><br/>           Provident Hospital, Inc.<br/>           1514 Division Street<br/>           Baltimore, Maryland 21217         </div> <div> <b>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</b> </div> </div>   |  |  |  | <b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)<br><div style="display: flex; justify-content: space-between;"> <div> <b>A. STATE</b><br/>           Maryland         </div> <div> <b>B. COUNTY</b><br/>           1604         </div> </div> |  |  |  |                 |  |
|   |  |  |  | <b>C. CITY OR TOWN</b><br>Baltimore  |  | <b>D. INSIDE CITY LIMITS?</b><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                 |  |
|   |  |  |  | <b>E. STREET AND NUMBER</b><br>1020 N. Fulton Avenue   |  |  |  |                 |  |
| <b>5. SEX</b><br>Male   |  | <b>6. RACE</b><br>Negro  |  | <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>  |  | <b>8. DATE OF BIRTH</b><br>11-15-20  |  |                 |  |
|   |  |  |  | <b>9. AGE</b> (In years lost birthday)<br>48   |  | <b>10. UNDER 1 Yr.</b> Months Days <b>11. UNDER 24 Hrs.</b> Hours Min.                               |  |                 |  |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br>Unemployed  |  |  |  | <b>10B. KIND OF BUSINESS OR INDUSTRY</b>   |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br>Virginia   |  |                 |  |
| <b>12. CITIZEN OF WHAT COUNTRY?</b><br>U. S. A.   |  |  |  |  |  |  |  |                 |  |
| <b>13. FATHER'S NAME</b><br>Howard Rudd   |  |  |  | <b>14. MOTHER'S MAIDEN NAME</b><br>Emma Bunch  |  |  |  |                 |  |
| <b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)<br>yes B/18/43*11/16/45   |  |  |  | <b>16. SOCIAL SECURITY NO.</b><br>223079624  |  | <b>17. INFORMANT</b><br>Mrs. Adelaide Smith (Sister) 1031 N. Sarahann St.                            |  |                 |  |
| <b>18. CAUSE OF DEATH</b><br><div style="display: flex; justify-content: space-between;"> <div> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br/>           (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br/>           ANTECEDENT CAUSES<br/>           DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.         </div> <div> <b>(A) IMMEDIATE CAUSE</b><br/>           Hepatic Coma<br/> <b>DUE TO, OR AS A CONSEQUENCE OF:</b><br/>           Uremia         </div> <div> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b><br/> <br/> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b><br/> <br/> </div> </div> |  |  |  | <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>  |  |  |  |                 |  |
| <b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>  |  |  |  |  |  |  |  |                 |  |
| <b>19A. DATE OF OPERATION</b><br>0  |  | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>  |  | <b>20A. AUTOPSY?</b> (Yes or No)<br>No   |  | <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>                          |  |                 |  |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>   |  | <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)  |  |  |  |                 |  |
| <b>21D. TIME OF INJURY (APPROX.)</b><br>(Month) (Day) (Year) (Hour)   |  | <b>21E. INJURY OCCURRED</b><br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | <b>21F. HOW DID INJURY OCCUR?</b>  |  |  |  |                 |  |
| <b>22. I certify that (I) (this hospital) attended the deceased from</b> 10-28-69 <b>19</b> <b>to</b> 11-2-69 <b>19</b><br><b>that (I) (we) last saw the deceased alive on</b> 11-2-69 <b>19</b> <b>and that in (my) (our) opinion death occurred on the date</b><br><b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>  |  |  |  |  |  |  |  |                 |  |
| <b>23A. SIGNATURE</b><br><div style="text-align: center;"> <br/>           G. TENGOCO M.D.         </div>   |  |  |  | <b>23B. DATE SIGNED</b><br>11-2-69   |  | <b>23C. PHYSICIAN'S NAME (Type)</b><br>G. TENGOCO M.D.   |  |                 |  |
| <b>24A. BURIAL CREMATION, REMOVAL (Specify)</b><br>Burial   |  | <b>24B. DATE</b><br>22-6-69  |  | <b>24C. NAME OF CEMETERY OR CREMATORY</b><br>Balto. Nat'l. Cem.  |  | <b>24D. LOCATION</b> (City, town, or county) (State)<br>Baltimore, Maryland                          |  |                 |  |
| <b>25A. DATE REC'D BY HEALTH DEPT.</b><br>NOV 4 1969  |  | <b>25B. NAME OF REGISTRAR</b><br>V. Bailey   |  | <b>25C. FUNERAL DIRECTOR</b><br>Kelson F.H.  |  | <b>ADDRESS</b><br>1348 Calhoun St.   |  |                 |  |





H-400

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 10832

|   |  |  |  |
|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br>JAMES L. HALL   |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> M.                     |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>1513 N. Calhoun Street (DOA)  |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br>November 2, 1969 8:25 A.M.   |  |
| 6. SEX<br>Male  |  | 7. RACE<br>Negro   |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | C. CITY OR TOWN<br>Baltimore   |  |
| 9. DATE OF BIRTH<br>3-16-10   |  | 10. AGE (In years lost birthday)<br>59   |  |
| 11. BIRTHPLACE (State or foreign country)<br>Md.  |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 14A. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland  |  | B. COUNTY 1501   |  |
| 14B. KIND OF BUSINESS OR INDUSTRY   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                  |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no or unknown) (if yes, give war or dates of service)<br>no  |  | 17. SOCIAL SECURITY NO.  |  |
| 18. INFORMANT<br>Elvira Braxton   |  | ADDRESS<br>same  |  |
| 19. 560.2<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>Peritonitis and bowel obstruction  |  | CAUSE OF DEATH<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) Sigmoid Volvulus<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____ |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |  |  |
| 20A. DATE OF OPERATION<br>2   |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                       |  |
| 22D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)  |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                      |  |
| 22C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |  | 22F. HOW DID INJURY OCCUR?   |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE: <i>Ronald N. Kornblum</i> M.D.<br>EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.<br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED 11/2/69 |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |  | 24B. DATE<br>11-6-69   |  |
| 24C. NAME OF CEMETERY or CREMATORY<br>Mt. Calvary Cem.  |  | 24D. LOCATION (City, town, or county) (State)<br>Balto. Md.  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 4 1969   |  | 25B. NAME OF REGISTRAR<br>Robert F. Bailey, M.D.   |  |
| 25C. FUNERAL DIRECTOR/V. Bailey ADDRESS<br>Kelson, F.H. 1348 Calhoun Street   |  |  |  |

SECRET

2



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                      |   |   |
|--|----------------------|---|---|
| BALTIMORE CITY HEALTH DEPARTMENT   |                      | REG. NO. <b>69 10833</b>  |   |
| L-520  |                      | 69 10833 CERTIFICATE OF DEATH   |   |
| BIRTH NO.  |                      | 2. DATE AND HOUR OF DEATH   |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Frieda Long (Frieda Helene Long)</b>   |                      | 10-31-69 9:30 A. M.   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                      | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b># 21234 5300</b>  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Harbor View Nursing Center</b><br><b>1213 Light Street</b>  |                      | C. CITY OR TOWN <b>Baltimore</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |
| E. STREET AND NUMBER <b>2717 GLEN DALE ROAD</b>  |                      |   |   |
| 5. SEX <b>F.</b>   | 6. RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                           | 8. DATE OF BIRTH <b>1-31-1890</b>                           |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                      | 9. AGE (In years last birthday) <b>79</b>   | 11. BIRTHPLACE (State or foreign country)<br><b>Germany</b> |
| 10B. KIND OF BUSINESS OR INDUSTRY  |                      | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>Gustav A. Bachmann</b>   |                      | 14. MOTHER'S MAIDEN NAME<br><b>Bertha Frederick</b>   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>  |                      | 16. SOCIAL SECURITY NO. <b>218 50 7014 J-1</b>  |   |
|  |                      | 17. INFORMANT <b>Mr. Norman E. A. Long</b><br><b>2714 Glendale Rd. 21234</b>  |   |
| 18. <b>412.4</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |                      | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <b>A. S. C. V. D.</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <b>CONGESTIVE HEART FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____ |   |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |                      |   |   |
| 19A. DATE OF OPERATION <b>0</b>  |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |
| 20A. AUTOPSY? (Yes or No) <b>No</b>  |                      | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                      |   |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |                      | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |   |
| 21F. HOW DID INJURY OCCUR?   |                      |   |   |
| 22. I certify that (this hospital) attended the deceased from <b>10-9 1969</b> to <b>10-31 1969</b> , that (we) lost the deceased alive on <b>10-31 1969</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                      |   |   |
| 23A. SIGNATURE <b>Mr. A. Gongon, M.D.</b>  |                      | 23B. DATE SIGNED <b>10-31-69</b>  |   |
| 23C. PHYSICIAN'S NAME (Type) <b>MANUEL A. GONGON, M.D.</b>   |                      | 23D. ADDRESS <b>5701 THE ALAMEDA, BALTO. MD. 21212</b>  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>   |                      | 24B. DATE <b>Nov. 3, 1969</b>   |   |
| 24C. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>  |                      | 24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>  |   |
| 25. DATE REC'D BY HEALTH DEPT. <b>NOV 4 1969</b>   |                      | 25C. FUNERAL DIRECTOR <b>HENRY SANDER &amp; SONS, INC.</b>  |   |
| 25B. NAME OF REGISTRAR <b>19590000</b>   |                      | ADDRESS <b>Baltimore Md.</b>  |   |

DATE

1900

1900

B-246

69 10834

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 10834

BIRTH NO.

|   |  |  |  |
|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>JAMES <del>W.</del> BUCKLER</b>   |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> 10 30 69 12:34 <sup>PM</sup> |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>St. Agnes Hospital D.O.A.</b> |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>Oct. 30, 1969 12:34 PM</b>  |  |
| 6. SEX<br><b>Male</b>   |  | 7. RACE<br><b>White</b>  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>St. Mary's</b>        |  |
| 9. DATE OF BIRTH<br><b>Nov. 22, 1950</b>  |  | 10. AGE (In years last birthday) <b>18</b><br>If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 14B. KIND OF BUSINESS OR INDUSTRY  |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |  | 17. SOCIAL SECURITY NO.  |  |
| 18. INFORMANT<br><b>Joseph L. Buckler</b>   |  | ADDRESS<br><b>Mechanicsville, Maryland</b>   |  |
| 15. MOTHER'S MAIDEN NAME<br><b>Mary Florence Owens</b>  |  | E. STREET AND NUMBER<br><b>Mechanicsville, Md. Trent Hall</b>  |  |

|   |  |  |   |   |  |
|---|--|--|---|---|--|
| MEDICAL CERTIFICATION   | 19. <b>E 882 X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <b>Multiple injuries</b><br>DUE TO, OR AS A CONSEQUENCE OF: |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|   | ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |  | (B) DUE TO, OR AS A CONSEQUENCE OF:   |   |  |
|   | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |  | (C) DUE TO, OR AS A CONSEQUENCE OF:   |   |  |
|   | 20A. DATE OF OPERATION<br><b>2</b>   |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Construction site</b> |   | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br><b>Hannibal Grove Apts. Tin Mill Rd. 6300</b> |  |
| 22D. TIME OF INJURY (APPROX.)<br>10 30 69 11:40 <sup>a</sup>  |  | 22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>    |   | 22F. HOW DID INJURY OCCUR?<br><b>Columbia, Md. Subject was working on roof, fell to the ground</b>                        |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |   |   |  |
| ACTUAL EXAMINER'S NAME (Type) <b>Isidore Mihalakis, M.D.</b>  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   | DATE SIGNED <b>10/31/69</b>   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 24B. DATE<br><b>Nov. 3, 1969</b>   |   | 24C. NAME OF CEMETERY or CREMATORY<br><b>Sacred Heart Cemetery</b>  |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Bushwood, St. Mary's, Maryland</b>  |  | 25A. DATE RECEIVED BY HEALTH DEPT.<br><b>Nov 4 1969</b>  |   | 25C. FUNERAL DIRECTOR ADDRESS<br><b>W. Clarke Mattingley Leonardtown, Maryland</b>  |  |

CS 10834

CS 10834

WALLACE

H-630

69 10835

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 10835

|   |  |  |  |
|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>JOHN F. HIRT</b>   |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> M.  |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>33 JOHNS HOPKINS HOSPITAL</b><br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>November 1, 1969 2:30 P. M.</b>   |  |
| 6. SEX<br><b>Male</b>   |  | 7. RACE<br><b>White</b>  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | C. CITY OR TOWN<br><b>Baltimore</b>  |  |
| 9. DATE OF BIRTH<br><b>March 9, 1891</b>  |  | 10. AGE (In years last birthday)<br><b>78</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Carpenter</b>   |  | 14B. KIND OF BUSINESS OR INDUSTRY<br><b>Bldg. Trade</b>  |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |  | 17. SOCIAL SECURITY NO.<br><b>214 03 3780A</b>   |  |
| 13. FATHER'S NAME<br><b>John J. Hirt</b>  |  | 15. MOTHER'S MAIDEN NAME<br><b>Anna Svec</b>   |  |
| 18. INFORMANT<br><b>John A. Hirt</b>  |  | ADDRESS<br><b>837 N. Luzerne Avenue</b>  |  |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>412.4</b>  |  | CAUSE OF DEATH<br><b>Arteriosclerotic Cardiovascular Disease</b>   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:   |  |
|   |  | (B) DUE TO, OR AS A CONSEQUENCE OF:  |  |
|   |  | (C) DUE TO, OR AS A CONSEQUENCE OF:  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |  |  |  |
| 20A. DATE OF OPERATION<br><b>11-5-69</b>  |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  | 22D. TIME OF INJURY (Approx.)  |  |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 22F. HOW DID INJURY OCCUR?   |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |
| ACTUAL EXAMINER'S NAME (Type)<br><b>Ronald N. Kornblum, M.D.</b>  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 24B. DATE<br><b>11-5-69</b>  |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Holy Redeemer Cemetery</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 4 1969</b>  |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor</b>  |  |
| 25C. FUNERAL DIRECTOR<br><b>Philip J. Cray</b>  |  | ADDRESS<br><b>1211 Chesaco Avenue</b>  |  |



ACADEMIC RECORD

ACADEMIC RECORD

ACADEMIC RECORD

ACADEMIC RECORD

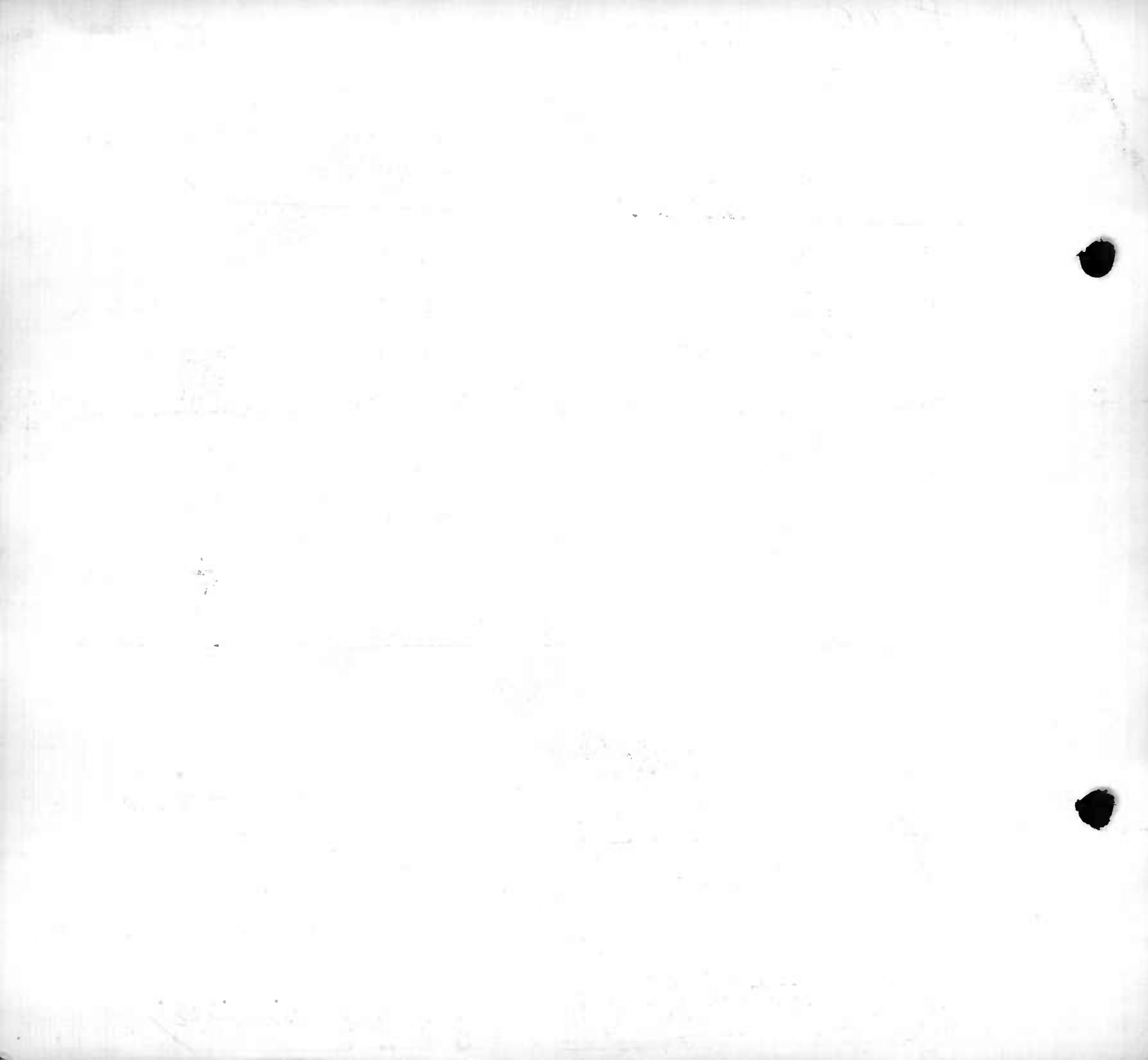
ACADEMIC RECORD



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                     |   |  |   |  |  |  |   |  |
|--|---------------------|---|--|---|--|--|--|---|--|
| T-600  |                     | 69 10836  |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | X  |  | REG. NO. 69 10836   |  |
| BIRTH NO.  |                     | 1. NAME OF DECEASED<br>(Type or Print) <b>TERESINA TORO</b>   |  |   |  | 2. DATE AND HOUR OF DEATH<br><b>October 30, 1969 1:00 P.M.</b>   |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                     |   |  |   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>35 CHURCH HOME AND HOSPITAL</b>  |                     |   |  |   |  | C. CITY OR TOWN <b>DUNDALK BALTIMORE</b>   |  | D. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  |
| E. STREET AND NUMBER<br><b>32 LIBERTY PKWY.</b>  |                     |   |  |   |  |  |  |   |  |
| 5. SEX<br><b>F</b>   | 6. RACE<br><b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>3/21/96</b>  |  | 9. AGE (in years last birthday) <b>73</b>  |  | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                     |   |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>ITALY</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Vide Dattoli</b>   |                     |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Rosina mers</b>  |  |  |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>  |                     |   |  | 16. SOCIAL SECURITY NO.<br><b>911-18-2774</b>   |  | 17. INFORMANT<br><b>Charles Toro (Husband)</b>   |  | ADDRESS<br><b>32 Liberty Pkwy.</b>  |  |
| 18. <b>4/10/91-25017</b> CAUSE OF DEATH  |                     |   |  |   |  |  |  |   |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Acute myocardial infarction</b>   |                     |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days (?)</b>  |  |   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>arteriosclerotic heart disease</b>  |                     |   |  |   |  | DUE TO, OR AS A CONSEQUENCE OF:<br><b>diabetes mellitus</b>  |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>Diabetes mellitus</b>   |                     |   |  |   |  |  |  |   |  |
| 19A. DATE OF OPERATION<br><b>0</b>   |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                     |   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |   |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |                     |   |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |   |  |
| 22. I certify that <del>(I)</del> <b>(we)</b> <del>(this hospital)</del> attended the deceased from <b>October 21</b> 19 <b>69</b> to <b>October 30</b> 19 <b>69</b> that <del>(I)</del> <b>(we)</b> last saw the deceased alive on <b>October 30</b> 19 <b>69</b> and that <del>(my)</del> <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. <del>(I)</del> <b>(We)</b> <del>(did)</del> <b>(did not)</b> view the body after death. |                     |   |  |   |  |  |  |   |  |
| 23A. SIGNATURE<br><b>Rolando A. Mendoza</b>  |                     |   |  |   |  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>              |  | 23B. DATE SIGNED<br><b>10/30/69</b>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>ROLANDO A. MENDOZA MD.</b>  |                     |   |  |   |  | 23D. ADDRESS<br><b>100 N. Broadway St., Balt., MD.</b>   |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                     | 24B. DATE<br><b>11/3/69</b>   |  | 24C. NAME of CEMETERY or CREMATORY<br><b>OAK LAWN</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>BALTO. CO., MD.</b>  |  |   |  |
| 25A. DATE REC'D BY HEALTH DEPT. & C. REGISTRAR<br><b>NOV 4 1969</b>  |                     |   |  |   |  | 25C. FUNERAL DIRECTOR<br><b>WALTER BROOKS BRADLEY DUNDALK, MD.</b>   |  |   |  |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                 |   |   |   |   |  |                              |
|--|-----------------|---|---|---|---|--|------------------------------|
| S-160  |                 | 69 10838  |   | BALTIMORE CITY HEALTH DEPARTMENT  |   | REG. NO. 69 10838  |                              |
| BIRTH NO.  |                 |   |   | 110 M.  |   |  |                              |
| 1. NAME OF DECEASED<br>(Type or Print) Earl A. Schaeffer   |                 |   |   | 2. DATE AND HOUR OF DEATH<br>10-29-1969   |   |  |                              |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                 |   |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Md. B. COUNTY Baltimore |   |  |                              |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>North Charles General Hospital  |                 |   |   | C. CITY OR TOWN Baltimore   |   |  |                              |
| D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                 |   |   | E. STREET AND NUMBER<br>1232 Kahler Avenue  |   |  |                              |
| 5. SEX<br>Male   | 6. RACE<br>Cau. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>      | 8. DATE OF BIRTH<br>1-31-1904                           | 9. AGE (In years last birthday)<br>65   | If Under 1 Yr. Months: Days: Hours: Min.                    |  |                              |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Mill Foreman  |                 |   | 10B. KIND OF BUSINESS OR INDUSTRY<br>Bethlehem Steel Co |   | 11. BIRTHPLACE (State or foreign country)<br>Tamaqua, Penna |  | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME<br>John A. Schaeffer   |                 |   | 14. MOTHER'S MAIDEN NAME<br>Mary E. Mellon              |   |   |  |                              |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No   |                 |   | 16. SOCIAL SECURITY NO.<br>186-01-1679                  |   | 17. INFORMANT<br>Henry M. Decker Jr. Aurora Federal Bldg    |  |                              |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>Pulmonary embolism   |                 |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 day   |   |  |                              |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.   |                 |   |   |   |   |  |                              |
| II   |                 |   |   |   |   |  |                              |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (A).  |                 |   |   |   |   |  |                              |
| 19A. DATE OF OPERATION   |                 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)   |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                              |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)  |                 | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)   |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |  |                              |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |                 | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |   | 21F. HOW DID INJURY OCCUR?  |   |  |                              |
| 22. I certify that (I) (this hospital) attended the deceased from 1/25 to 10/29/69, that (I) (we) last saw the deceased alive on 10/29/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                 |   |   |   |   |  |                              |
| 23A. SIGNATURE<br>A. L. Kolodny, MD  |                 |   |   | 23B. DATE SIGNED<br>10/29/69  |   | 23C. PHYSICIAN'S NAME (Type)<br>A. L. Kolodny, MD                    |                              |
| 23D. ADDRESS<br>1325 Eastern Blvd<br>Baltimore, MD 21221   |                 | 23E. ATTENDING PHYSICIAN<br>Attending <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |   | 23F. ADDRESS<br>1325 Eastern Blvd<br>Baltimore, MD 21221  |   |  |                              |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial   |                 | 24B. DATE<br>11-1-1969  |   | 24C. NAME OF CEMETERY or CREMATORY<br>Moreland Memorial Cem.  |   | 24D. LOCATION (City, town, or county) (State)<br>Baltimore Md        |                              |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 4 1969  |                 | 25B. NAME OF REGISTRAR<br>R. E. Fisher, MD  |   | 25C. FUNERAL DIRECTOR<br>L. J. J. J.  |   | 25D. ADDRESS<br>7401 Belair Road 21236                               |                              |

11/18/69 - Correction form from funeral director.

11/20/69 - Letter from Atty. Henry M. Decker, Jr. *HBC*

Insurance policy from PrudentialLife Insurance  
Policy -22 114 850. Issued: 2/28/1961.

Birth date: 1/31/1904. *HBC*

R-240

69 10837

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

69 10837

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Gertrude Rasel

2. DATE AND HOUR OF DEATH

10/28/69 1 830 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITALS

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

Maryland Baltimore

Dundalk

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

255 Saint Helena Avenue 21222

5. SEX

Female

6. RACE

White

7. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

8-14-83

9. AGE (in years  
last birthday)

86

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

At home

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William J. Nichols

14. MOTHER'S MAIDEN NAME

Katy Paymire

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

218-09-9489

17. INFORMANT

BCH: Records

ADDRESS

4940 Eastern Avenue  
Baltimore, Maryland 21224

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

minutes

many years

11  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

anemia; advanced cavity Tbc

10 yrs

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10/6 19 69 to 10/28 19 69  
that (I) (we) last saw the deceased alive on 10/28 19 69 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

J.R. Neeffe MD

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

10/28/69

23C. PHYSICIAN'S  
NAME (Type)

J.R. NEEFFE M.D.

23D. ADDRESS

Baltimore City Hospitals 21224  
4940 Eastern Avenue Baltimore, Maryland 224A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

10/31/69

24C. NAME of CEMETERY or CREMATORY

Sacred Heart

24D. LOCATION

(City, town, or county)

(State)

Dundalk, Md.

25A. DATE REC'D BY HEALTH DEPT.

NOV 4 1969

25B. NAME OF HEALTH DEPT.

Robert E. Bailey

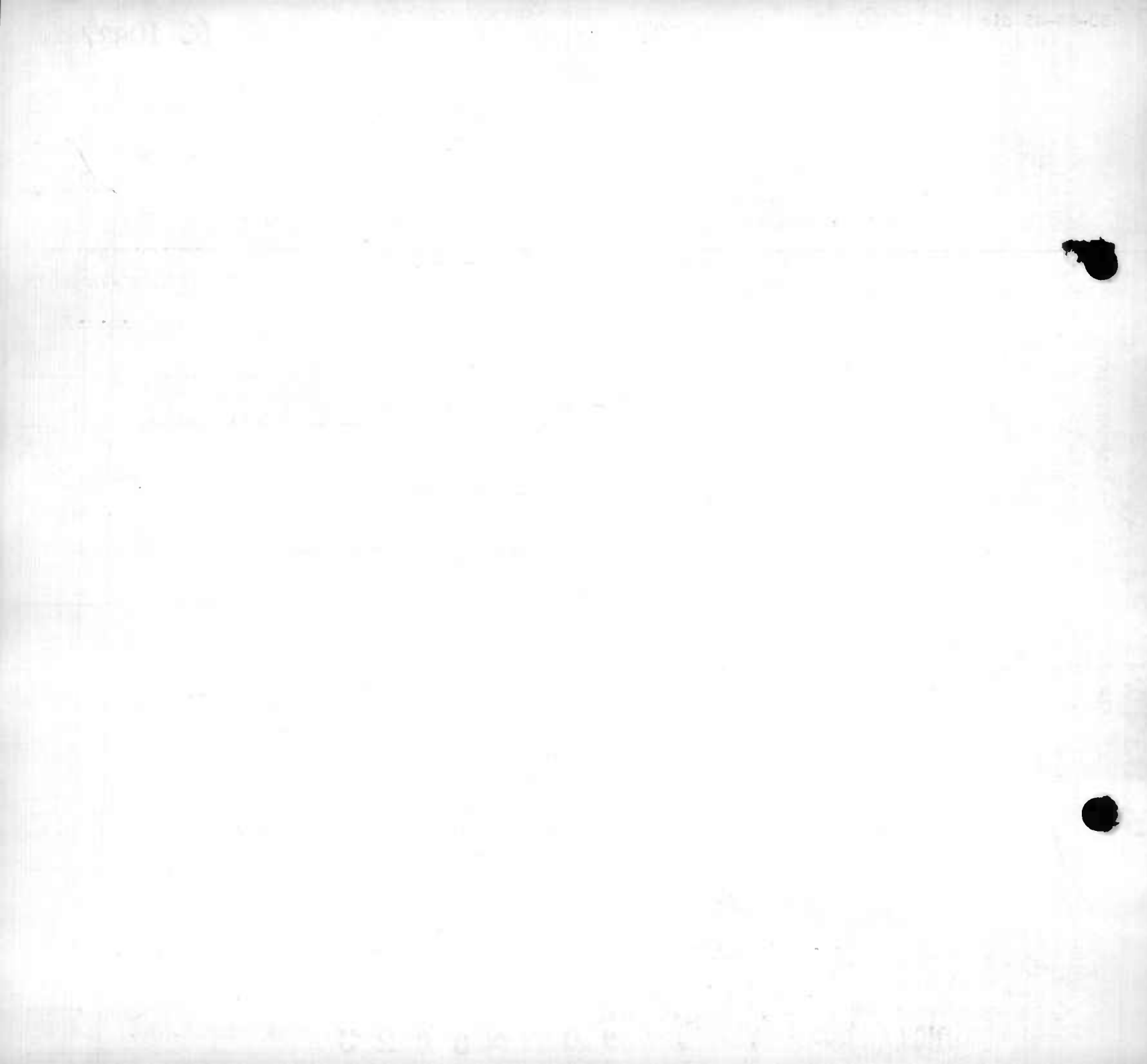
25C. FUNERAL DIRECTOR

Ulrich Funeral Home Dundalk, Md.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

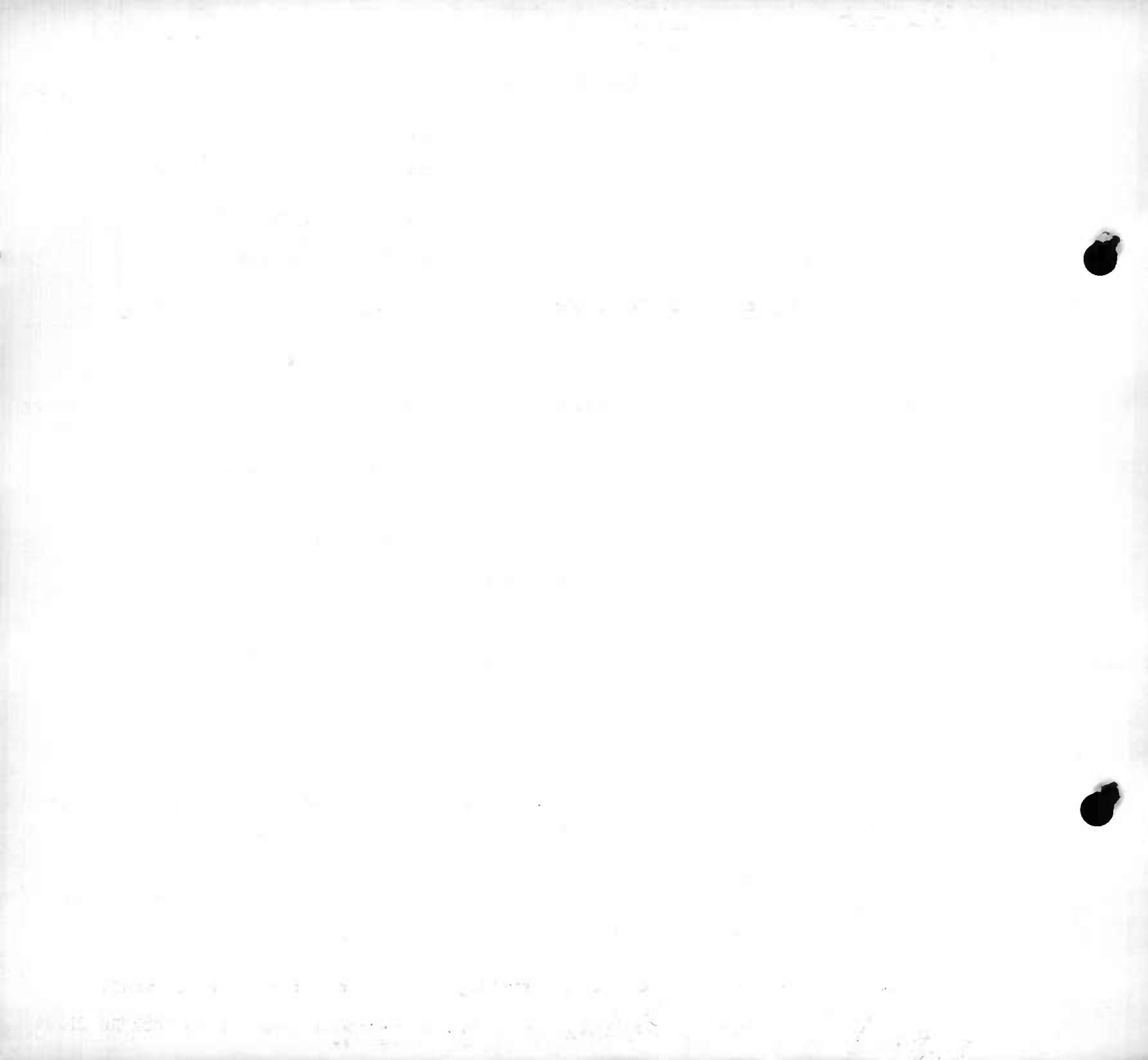
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |                         |   |  | REG. NO. <u>69 10839</u>                  |  |
|--|-------------------------|---|--|---|--|
| BIRTH NO. <u>R-543</u>   |                         | 69 10839  |  | CERTIFICATE OF DEATH                      |  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>REYNOLDS, CHARLES E. SR.</u>   |                         |   | 2. DATE AND HOUR OF DEATH<br><u>November 2nd, 1969</u> <u>6:35 P.M.</u>  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>4 UNION MEMORIAL HOSPITAL</u>  |                         |   | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>A. STATE <u>MARYLAND</u><br>B. COUNTY <u>1202</u><br>C. CITY OR TOWN <u>BALTIMORE</u><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <u>318 E. 33rd. Street</u> |   |  |
| 5. SEX<br><u>MALE</u>  | 6. RACE<br><u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>07/06/97</u>  | 9. AGE (In years last birthday) <u>72</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.       |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>RETIRED -Tyler</u>   |                         |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Masonic Temple</u>   |   | 11. BIRTHPLACE (State or foreign country)<br><u>MARYLAND</u> |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |                         |   | 13. FATHER'S NAME<br><u>HARVEY J. REYNOLDS</u>   |   |  |
| 14. MOTHER'S MAIDEN NAME<br><u>MARGARET MC CALLISTER</u>   |                         |   | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>  |   |  |
| 16. SOCIAL SECURITY NO.<br><u>215-09-5020</u>  |                         |   | 17. INFORMANT<br><u>MARION W. REYNOLDS</u> ADDRESS <u>SAME AS ABOVE</u>  |   |  |
| 18. <u>43391</u> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>II</u><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br>19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>20A. AUTOPSY? (Yes or No) <u>No</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)<br>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/><br>21F. HOW DID INJURY OCCUR?<br>22. I certify that (I) (this hospital) attended the deceased from <u>October 20th 1969</u> to <u>November 2nd 1969</u> that (I) (we) last saw the deceased alive on <u>November 2nd 1969</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.<br>23A. SIGNATURE <u>J. Cabrera</u> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> 23B. DATE SIGNED <u>October November 2nd, 1969</u><br>23C. PHYSICIAN'S NAME (Type) <u>CABRERA JUAN M. M.D.</u> 23D. ADDRESS <u>UNION MEMORIAL HOSPITAL</u><br>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> 24B. DATE <u>11-5-</u> 24C. NAME OF CEMETERY OR CREMATORY <u>New Oxford Cemetery</u> 24D. LOCATION (City, town, or county) (State) <u>New Oxford, Pennsylvania</u><br>25A. DATE REC'D BY HEALTH DEPT. <u>NOV 4 1969</u> 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> 25C. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook-Brooks Towson 1050 York Rd 21204</u> |                         |   |  |   |  |





B-620

69 10840 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 10840

BIRTH NO.

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>FRED GROSS</b>   |  |   |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> 10 30 69 4:15 p.m.   |  |   |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>2114 E. Balto. St.</b>   |  |   |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>Oct. 30 1969 4:15 p.m.</b>  |  |   |  |
| 6. SEX<br><b>Male</b>   |  |   |  | 7. RACE<br><b>White</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. DATE OF BIRTH<br>10. AGE (In years lost birthday)<br><b>70</b>   |  |   |  | E. STREET AND NUMBER<br><b>2114 E. Balto. St.</b>  |  |   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore</b>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 13. FATHER'S NAME<br><b>Frederick Gross</b>   |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>   |  |   |  | 14B. KIND OF BUSINESS OR INDUSTRY<br><b>215-70-8216</b>  |  | 15. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Unknown</b>   |  |   |  | 17. SOCIAL SECURITY NO.<br><b>215-70216</b>  |  | 18. INFORMANT<br><b>Clara Gross - 120 N. E. St.</b>   |  |
| 19. <b>4-12-21</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |  |   |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <b>Hypertensive cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) _____<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) _____ |  |   |  |
| 20A. DATE OF OPERATION<br><b>11/3/69</b>  |  |   |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |   |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?  |  |
| 22D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)  |  |   |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 22F. HOW DID INJURY OCCUR?  |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br><br>ACTUAL SIGNATURE <b>Isidore Mihalakis, M.D.</b> M.D.<br>EXAMINER'S NAME (Type)<br><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br><br>DATE SIGNED <b>10/31/69</b> |  |   |  |  |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 24B. DATE<br><b>11/3/69</b>                             |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Oak Lawn Cemetery</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>7225 Eastern Ave. Baltimore, Md.</b>  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 4 1969</b>  |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Garber, M.D.</b> |  | 25C. FUNERAL DIRECTOR ADDRESS<br><b>Faulkner &amp; Moller Inc 3019 E. Monument St.</b>   |  |   |  |

CS 10340

CS 10340

WALTER B. GORDON

Major General Walter B. Gordon  
The Adjutant General's Office  
The Adjutant General's Office  
The Adjutant General's Office

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |  |   |  | REG. NO. <b>69 10841</b>  |  |
|--|--|---|--|---|--|
| <b>R-423</b><br><b>69 10841</b><br><b>CERTIFICATE OF DEATH</b>   |  | <b>1. NAME OF DECEASED</b><br>(Type or Print) <b>KENNETH E. ROLLSTON</b>  |  |   |  |
| <b>2. DATE AND HOUR OF DEATH</b><br><b>6:55 AM 11/2/69</b>   |  | <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><b>JOHNS HOPKINS HOSPITAL</b><br><b>33 BALTIMORE, MD 21205</b>   |  |   |  |
| <b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>UNIVERSITY OF DELAWARE, DELAWARE</b><br>B. COUNTY <b>NEWARK</b><br>C. CITY OR TOWN <b>NEWARK</b><br>D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>E. STREET AND NUMBER <b>925 KENILWORTH AVE</b>   |  | <b>5. SEX</b> <b>M</b><br><b>6. RACE</b> <b>CAUCAS.</b><br><b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/><br><b>8. DATE OF BIRTH</b> <b>08/04/16</b><br><b>9. AGE</b> (In years last birthday) <b>53</b><br><b>10. A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>PHYSICIST</b><br><b>10. B. KIND OF BUSINESS OR INDUSTRY</b> <b>UNIVERSITY RESEARCH</b><br><b>11. BIRTHPLACE</b> (State or foreign country) <b>IRELAND</b><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <b>CANADA</b> |  |   |  |
| <b>13. FATHER'S NAME</b><br><b>Thomas Rhoulston</b>  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><b>EVELYN IRWIN</b>  |  |   |  |
| <b>15. Was Deceased Ever in U. S. Armed Forces?</b><br>(Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>  |  | <b>16. SOCIAL SECURITY NO.</b><br><b>213-48-8853</b>  |  | <b>17. INFORMANT</b><br><b>ROLLSTON</b><br><b>ADDRESS</b><br><b>925 KENILWORTH WILM. PER.</b> |  |
| <b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b><br><b>18.1</b><br><b>18.2</b><br><b>18.3</b><br><b>18.4</b><br><b>18.5</b><br><b>18.6</b><br><b>18.7</b><br><b>18.8</b><br><b>18.9</b><br><b>18.10</b><br><b>18.11</b><br><b>18.12</b><br><b>18.13</b><br><b>18.14</b><br><b>18.15</b><br><b>18.16</b><br><b>18.17</b><br><b>18.18</b><br><b>18.19</b><br><b>18.20</b><br><b>18.21</b><br><b>18.22</b><br><b>18.23</b><br><b>18.24</b><br><b>18.25</b><br><b>18.26</b><br><b>18.27</b><br><b>18.28</b><br><b>18.29</b><br><b>18.30</b><br><b>18.31</b><br><b>18.32</b><br><b>18.33</b><br><b>18.34</b><br><b>18.35</b><br><b>18.36</b><br><b>18.37</b><br><b>18.38</b><br><b>18.39</b><br><b>18.40</b><br><b>18.41</b><br><b>18.42</b><br><b>18.43</b><br><b>18.44</b><br><b>18.45</b><br><b>18.46</b><br><b>18.47</b><br><b>18.48</b><br><b>18.49</b><br><b>18.50</b><br><b>18.51</b><br><b>18.52</b><br><b>18.53</b><br><b>18.54</b><br><b>18.55</b><br><b>18.56</b><br><b>18.57</b><br><b>18.58</b><br><b>18.59</b><br><b>18.60</b><br><b>18.61</b><br><b>18.62</b><br><b>18.63</b><br><b>18.64</b><br><b>18.65</b><br><b>18.66</b><br><b>18.67</b><br><b>18.68</b><br><b>18.69</b><br><b>18.70</b><br><b>18.71</b><br><b>18.72</b><br><b>18.73</b><br><b>18.74</b><br><b>18.75</b><br><b>18.76</b><br><b>18.77</b><br><b>18.78</b><br><b>18.79</b><br><b>18.80</b><br><b>18.81</b><br><b>18.82</b><br><b>18.83</b><br><b>18.84</b><br><b>18.85</b><br><b>18.86</b><br><b>18.87</b><br><b>18.88</b><br><b>18.89</b><br><b>18.90</b><br><b>18.91</b><br><b>18.92</b><br><b>18.93</b><br><b>18.94</b><br><b>18.95</b><br><b>18.96</b><br><b>18.97</b><br><b>18.98</b><br><b>18.99</b><br><b>18.100</b> |  | <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b><br><b>SEXUAL WEEKS</b><br><b>8 YEARS</b>  |  |   |  |
| <b>19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b><br><b>19A. DATE OF OPERATION</b> <b>2</b><br><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b><br><b>19C. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>19D. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)<br><b>19E. INJURY OCCURRED</b><br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/><br><b>19F. HOW DID INJURY OCCUR?</b>  |  | <b>20. AUTOPSY?</b> (Yes or No) <b>YES</b><br><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>   |  |   |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>10/22/69</b> <b>19 69</b> <b>to</b> <b>11/2</b> <b>19 69</b><br><b>that (I) (we) lost saw the deceased alive on</b> <b>11/1</b> <b>19 69</b> <b>and that in (my) (our) opinion death occurred on the date</b> <b>11/2</b> <b>19 69</b><br><b>and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</b>  |  | <b>22. SIGNATURE</b><br><b>Thomas S. Inui</b><br><b>23. PHYSICIAN'S NAME (Type)</b> <b>THOMAS S. INUI</b><br><b>24. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Removal</b><br><b>24B. DATE</b> <b>11-3-69</b><br><b>24C. NAME of CEMETERY or CREMATORY</b> <b>Garry Park</b><br><b>24D. LOCATION</b> (City, town, or county) (State) <b>Winnipeg I. Manitoba, Canada</b>  |  |   |  |
| <b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>NOV 4 1969</b><br><b>25B. NAME OF REGISTRAR</b> <b>Robert E. Taylor, M.D.</b><br><b>25C. FUNERAL DIRECTOR</b> <b>H.W. Jenkins &amp; Sons Co., Balto., Md.</b>  |  | <b>26. DATE SIGNED</b> <b>11/2/69</b><br><b>27. ADDRESS</b> <b>JOHNS HOPKINS HOSPITAL, BALTIMORE, MD.</b>   |  |   |  |

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                  |   |                                   |   |                            |  |                             |
|---|------------------|---|-----------------------------------|---|----------------------------|--|-----------------------------|
| W-300   |                  | 69 10842  |                                   | BALTIMORE CITY HEALTH DEPARTMENT  |                            | REG. NO. 69 10842  |                             |
| BIRTH NO.   |                  |   |                                   | 1. NAME OF DECEASED<br>(Type or Print) Miss Alice Wood  |                            |  |                             |
| 2. DATE AND HOUR OF DEATH<br>Nov. 3, 1969 9:15 A. M.  |                  |   |                                   | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                            |  |                             |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>91  |                  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>Jenkins Memorial Hospital<br>1000 S. Caton Avenue<br>Baltimore, Maryland 21229      |                                   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Md.<br>B. COUNTY  |                            | C. CITY OR TOWN<br>Baltimore   |                             |
|   |                  |   |                                   | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                            | E. STREET AND NUMBER<br>3716 Tudor Arms Ave. 21211                           |                             |
| 5. SEX<br>Female  | 6. RACE<br>White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>Jan. 19, 1897 | 9. AGE (In years last birthday)<br>72   | If Under 1 Yr. Months Days |  | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Art Teacher  |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>Dept. of Education   |                                   | 11. BIRTHPLACE (State or foreign country)<br>Maryland   |                            | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                       |                             |
| 13. FATHER'S NAME<br>William Wood   |                  | 14. MOTHER'S MAIDEN NAME<br>Mary E. McColm  |                                   | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No  |                            |  |                             |
| 16. SOCIAL SECURITY NO.<br>213-48-7454T   |                  | 17. INFORMANT ADDRESS<br>Jenkins Memorial - 1000 S. Caton Ave., 21229   |                                   |   |                            |  |                             |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>250.7 I<br>CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                  |   |                                   | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>RENAL FAILURE<br>(B) Kimmelsteil-Wilson's Disease<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DIABETES MELLITUS |                            |  |                             |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                  |   |                                   | HASCVD  |                            |  |                             |
| 19A. DATE OF OPERATION<br>0   |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                   | 20A. AUTOPSY? (Yes or No)<br>No   |                            | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?         |                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                   | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |                            |  |                             |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)   |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                                   | 21F. HOW DID INJURY OCCUR?  |                            |  |                             |
| 22. I certify that (I) (this hospital) attended the deceased from OCT. 1 1969 to NOV. 3 1969, that (I) (we) last saw the deceased alive on NOV. 1 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                  |   |                                   |   |                            |  |                             |
| 23A. SIGNATURE<br>John F. Hartman, M.D.   |                  |   |                                   | 23B. DATE SIGNED<br>Nov. 3, 1969  |                            | 23C. PHYSICIAN'S NAME (Type)<br>JOHN F. HARTMAN, M.D.                        |                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |                  | 24B. DATE<br>11/5/69  |                                   | 24C. NAME OF CEMETERY or CREMATORY<br>Druid Ridge   |                            | 24D. LOCATION (City, town, or county) (State)<br>Pikesville, Balto. Co., Md. |                             |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 4 1969   |                  | 25B. NAME OF REGISTRAR<br>John E. Baker, M.D.   |                                   | 25C. FUNERAL DIRECTOR<br>H. W. Jenkins & Sons Co.   |                            | ADDRESS<br>4905 York Rd. Balto. Md. 21212                                    |                             |



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 10843

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Shawn McNeil

2. DATE  
OF  
DEATHKnown ☐  
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

11

2

69

9:50 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

7/5/64

10. AGE (In years  
last birthday)11 Under 1 Yr. 11 Under 24 Hrs.  
Months Days Hours Min.

3 1/2

E. STREET AND NUMBER

2750 W. Fairmount Avenue

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

15. MOTHER'S MAIDEN NAME

Shawn McNeil  
2750 W. Fairmount Avenue16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Shawn McNeil  
2750 W. Fairmount Avenue

19.

795-X  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

## CAUSE OF DEATH

Sudden death in infancy

## (A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

## (B)

DUE TO, OR AS A CONSEQUENCE OF:

## (C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11-3-69

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

11/5/69

24C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cemetery

24D. LOCATION (City, town, or county)

Baltimore Md

(State)

25A. DATE REC'D BY HEALTH DEPT

NOV 4 1969

25B. NAME OF REGISTRAR

Russell S. Fisher, M.D.

25C. FUNERAL DIRECTOR

William L. Fisher, M.D.  
2302 W. Fairmount Avenue

ADDRESS

1901

1901





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| BIRTH NO. <b>8-530</b>  |  | 69 10844   |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. <b>69 10844</b>  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Claude Smith</b>  |  |  |  | 2. DATE AND HOUR OF DEATH<br><b>Nov. 3, 1969 7 20 A.M.</b>  |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD.</b> 8. COUNTY <b>301</b>   |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>90 George Washington Nursing Home</b>  |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                 |  | C. CITY OR TOWN<br><b>Baltimore</b>   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 5. SEX<br><b>Male</b>   |  | 6. RACE<br><b>Negro</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>   |  | 9. AGE (In years last birthday)<br><b>Feb 28, 1907 72</b>                                     |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Long Shoreman</b>   |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><b>North Carolina</b>  |  | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME<br><b>George Smith</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>?</b>  |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>unknown</b>  |  |  |  | 16. SOCIAL SECURITY NO.<br><b>216-14-8324</b>   |  | 17. INFORMANT<br><b>Chart</b>   |  |
| 18. <b>185X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. |  |  |  | CAUSE OF DEATH<br><b>CHRONIC NEPHRITIS</b><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>ARTERIOSCLEROSIS OBLITERANS</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>URETERAL STRICTURE</b><br>(C) <b>BLADDER TRABECULATIONS</b> |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>YEARS</b>  |  |   |  |
| 19A. DATE OF OPERATION  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)             |  | 21C. WHERE DID INJURY OCCUR?  |  | (If in Baltimore City, give exact location)   |  |
| 21D. TIME OF INJURY (APPROX.)   |  | 21E. INJURY OCCURRED<br>While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |   |  |
| 22. I certify that (1) (this hospital) attended the deceased from <b>APRIL 25 1969</b> to <b>NOVEMBER 3 1969</b> , that (1) (we) last saw the deceased alive on <b>31 OCTOBER 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.        |  |  |  |   |  |   |  |
| 23A. SIGNATURE<br><b>Richard F. Tyson, M.D.</b>   |  |  |  | 23B. DATE SIGNED<br><b>11-3-69</b>  |  | 23C. ADDRESS<br><b>2320 Eutaw Place; Balto. Md. 21217</b>                                     |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |  | 24B. DATE  |  | 24C. NAME of CEMETERY or CREMATORY  |  | 24D. LOCATION (City, town, or county) (State)   |  |
| <b>Burial 11-3-69</b>   |  | <b>Nov 11 1969</b>   |  | <b>Mt Calvary</b>   |  | <b>Baltimore Md</b>   |  |
| 25A. DATE REC'D BY HEALTH DEPT.   |  | 25B. NAME OF REGISTRAR   |  | 25C. FUNERAL DIRECTOR   |  | ADDRESS   |  |
| <b>NOV 4 1969</b>   |  | <b>Robert E. Taylor</b>  |  | <b>Althea McQuinn</b>   |  | <b>3302 W. NORTH AVE</b>  |  |

George Washington Washington  
Male Negro  
Kings County  
George Smith  
?  
21-11-1871  
North Carolina

Feb 27 (1872)

St. M. (Caroline)

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                         |   |   | REG. NO. <b>69 10845</b>   |   |
|---|-------------------------|---|---|--|---|
| BIRTH NO. <b>69 10845</b>   |                         | CERTIFICATE OF DEATH  |   |  |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>HERMAN HEIL</b>   |                         |   | 2. DATE AND HOUR OF DEATH<br><b>10/31/69 6:45 PM</b>  |  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>MT SINAI NURSING HOME</b>   |                         |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>BALTIMORE</b><br>C. CITY OR TOWN <b>BALTIMORE</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>4613 PARK HEIGHTS AVENUE #15</b> |  |   |
| 5. SEX<br><b>MALE</b>   | 6. RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9-10-92</b>  | 9. AGE (In years last birthday)<br><b>77</b>                                   | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.       |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>SALESMAN</b>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>RETAIL</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>POLAND</b>                     |   |
| 13. FATHER'S NAME<br><b>UNKNOWN</b>   |                         |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |                         |   | 16. SOCIAL SECURITY NO.<br><b>128-03-1082</b>   |  | 17. INFORMANT<br><b>MR. DAVID KEIL, 2205 WALLACE AVENUE</b>     |
| 18. <b>I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.          |                         |   | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <b>Cancer - Pancreas</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) _____<br>(C) _____   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 months</b> |
| MEDICAL CERTIFICATION   |                         |   |   |  |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |                         |   |   |  |   |
| 19A. DATE OF OPERATION<br><b>0</b>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)       |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |   | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>July 1967</b> 19 to <b>Oct 31</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>Oct 15</b> 19 <b>69</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. |                         |   |   |  |   |
| 23A. SIGNATURE<br><b>Leon G. Sheet, M.D.</b>  |                         |   |   | 23B. DATE SIGNED<br><b>10/31/69</b>  |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>LEON G. SHEET, M.D.</b>  |                         |   |   | 23D. ADDRESS<br><b>6715 PARK HEIGHTS AVE</b>                                   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                         | 24B. DATE<br><b>11-4-69</b>   |   | 24C. NAME OF CEMETERY or CREMATORY<br><b>MIKRO KODESH-BETH ISRAEL</b>          |   |
| 24D. LOCATION<br><b>HERRING RUN, MARYLAND</b>   |                         | 24E. (City, town, or county) (State)  |   |  |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 4 1969</b>  |                         | 25B. NAME OF REGISTRAR<br><b>John E. Fisher, M.D.</b>   |   | 25C. FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BROS. 6010 Reisterstown Rd.</b> |   |

112-62-10000

11-10-61

WIFE

WIFE

100

112-62-10000

112-62-10000

112-62-10000

112-62-10000

112-62-10000

112-62-10000

# FUNERAL DIRECTOR: IMPORTANT

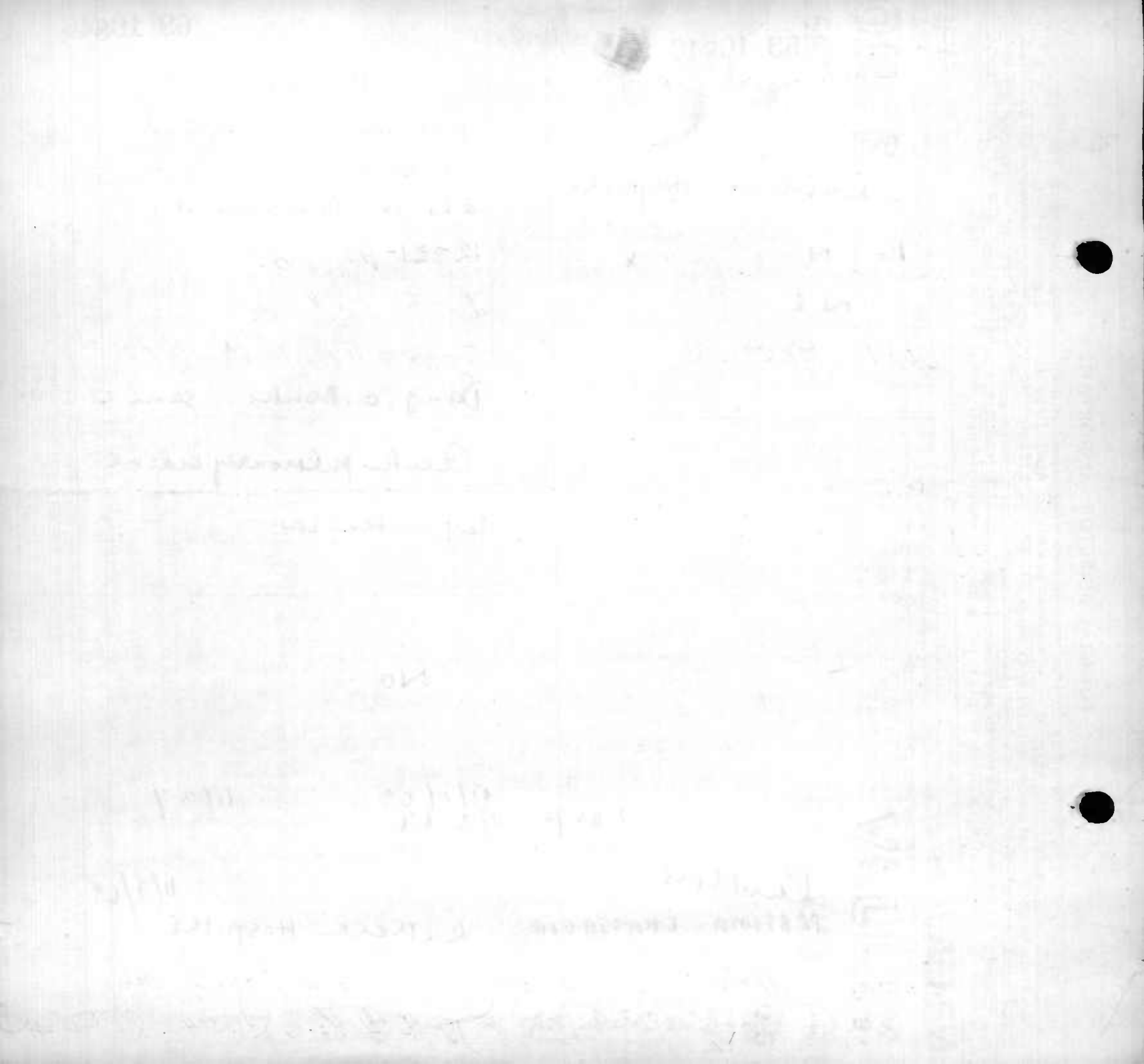
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO. 69 10846

|   |               |   |  |
|---|---------------|---|--|
| BIRTH NO. 69 10846  |               | 2. DATE AND HOUR OF DEATH<br>11.3.69. 1.05pm  |  |
| 1. NAME OF DECEASED<br>(Type or Print) HUGHLETT, CORDELLIA  |               | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE B. COUNTY<br>Baltimore Maryland 2037  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br>46 Lutheran Hospital   |               | C. CITY OR TOWN<br>Baltimore<br>D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| E. STREET AND NUMBER<br>219 N. Denison St.  |               |   |  |
| 5. SEX<br>F   | 6. RACE<br>N. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                       | 8. DATE OF BIRTH<br>12-31-99                     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>N.I.   |               | 10B. KIND OF BUSINESS OR INDUSTRY   | 9. AGE (In years last birthday)<br>69            |
| 11. BIRTHPLACE (State or foreign country)<br>Balt. Md   |               | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME<br>John Ambrose   |               | 14. MOTHER'S MAIDEN NAME<br>Henrietta Williams  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |               | 16. SOCIAL SECURITY NO.   | 17. INFORMANT<br>Daug, C. Banker. same as above. |
| 18. 401X I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)<br>ACUTE PULMONARY EDEMA<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. |               | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>Acute pulmonary edema.<br>Hypertension.<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF: |  |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |               |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |               |   |  |
| 19A. DATE OF OPERATION  |               | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20A. AUTOPSY? (Yes or No)<br>No   |               | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |               | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |               |   |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)  |               | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  |
| 21F. HOW DID INJURY OCCUR?  |               |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from 11/21/69 19 to 11/3/19 69, that (I) (we) last saw the deceased alive on 1.05pm 11/3/19.69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |               |   |  |
| 23A. SIGNATURE<br>Lester  |               | 23B. DATE SIGNED<br>11/3/69   |  |
| 23C. PHYSICIAN'S NAME (Type)<br>PRATIMA KHAISTAGIR  |               | 23D. ADDRESS<br>Lutheran Hospital   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |               | 24B. DATE<br>11/6/69  |  |
| 24C. NAME OF CEMETERY or CREMATORY<br>Mt. Calvary   |               | 24D. LOCATION (City, town, or county) (State)<br>A.A. County, Md  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 4 1969   |               | 25B. NAME OF REGISTRAR<br>Robert E. Taylor, M.D.  |  |
| 25C. FUNERAL DIRECTOR<br>Joseph J. Cook   |               | 25D. ADDRESS<br>1304 N. Central Ave   |  |



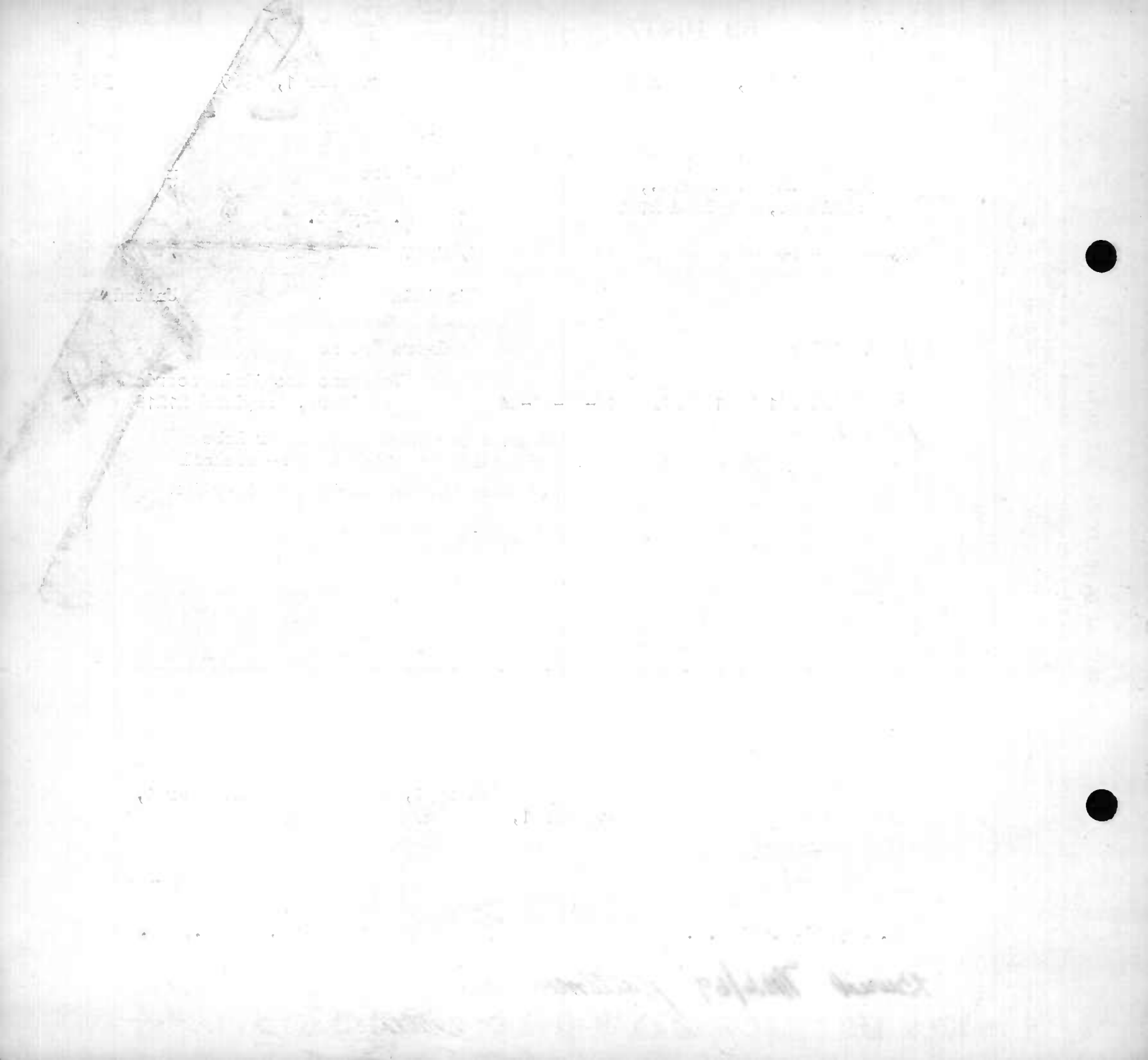
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 10847

# CERTIFICATE OF DEATH

|   |                         |  |  |
|---|-------------------------|--|--|
| BIRTH NO. 00-10817  |                         | DEATH NO. 00-10817   |  |
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>Fields, Leroy NMI</b>  |                         | 2. DATE AND HOUR OF DEATH<br><b>November 1, 1969 3:25 P.M.</b>   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><b>Veterans Administration Hospital<br/>3900 Loch Raven Blvd.,<br/>Baltimore, Maryland 21218</b>  |                         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>807</b><br>C. CITY OR TOWN <b>Baltimore</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>1420 N. Gay St.</b> |  |
| 5. SEX<br><b>Male</b>   | 6. RACE<br><b>Negro</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>4/24/07</b>           |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                         | 10B. KIND OF BUSINESS OR INDUSTRY  | 9. AGE (In years last birthday)<br><b>62</b> |
| 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>  |                         | 12. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  |
| 13. FATHER'S NAME<br><b>Robert Fields</b>   |                         | 14. MOTHER'S MAIDEN NAME<br><b>Elnora Greene</b>   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes 4/22/41 to 10/2/43</b>   |                         | 16. SOCIAL SECURITY NO.<br><b>219-05-53-24</b>   |  |
| 17. INFORMANT<br><b>Veterans Hospital Records<br/>Baltimore, Maryland 21218</b>   |                         | ADDRESS  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)<br><b>162.1 I</b><br><b>BRONCHOGENIC CARCINOMA LEFT UPPER LOBE WITH METASTASES TO HILAR &amp; PARA-TRACHEAL LYMPH NODES AND PERICARDIUM &amp; EPICARDIUM</b>   |                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b>   |                         | (A) IMMEDIATE CAUSE<br><b>PERICARDIAL EFFUSION MASSIVE</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |                         |  |  |
| 19A. DATE OF OPERATION<br><b>2</b>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20A. AUTOPSY? (Yes or No)<br><b>YES</b>   |                         | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  |
| 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |                         |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  |
| 21F. HOW DID INJURY OCCUR?  |                         |  |  |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 31, 1969</b> to <b>November 1, 1969</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>November 1, 1969</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death. |                         |  |  |
| 23A. SIGNATURE<br><b>M. J. Sharf</b>  |                         | 23B. DATE SIGNED<br><b>11-2-69</b>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>M. Javard Sharf M.D.</b>   |                         | 23D. ADDRESS<br><b>3900 Loch Raven Blvd. Balto., Md. 21218</b>   |  |
| 24A. BURIAL CREMATION REMOVAL (Specify)<br><b>Burial</b>  |                         | 24B. DATE<br><b>11/6/69</b>  |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Baltimore Natl Cem</b>   |                         | 24D. LOCATION (City, town, or county) (State)<br><b>5501 Fredrick Ave</b>  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>OCT 4 1969</b>  |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Elicker</b>   |  |
| 25C. FUNERAL DIRECTOR<br><b>11297</b>   |                         | ADDRESS  |  |







1  
F-208

## BALTIMORE CITY HEALTH DEPARTMENT

69 10848

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 10848

BIRTH NO.

|  |                         |   |   |
|--|-------------------------|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>ALBERT FOXX</b>  |                         | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> M.   |   |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>44 UNION MEMORIAL HOSPITAL</b>   |                         | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>November 1, 1969 3:59 P. M.</b>  |   |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>1203</b>  |                         |   |   |
| 6. SEX<br><b>Male</b>  | 7. RACE<br><b>White</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | C. CITY OR TOWN<br><b>Baltimore</b>   |
| 9. DATE OF BIRTH<br><b>8/21/15</b>   |                         | 10. AGE (In years lost birthday) <b>34</b><br>If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 11. BIRTHPLACE (State or foreign country)<br><b>Shennandorah, Co. Va.</b>  |                         | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>John Allen</b>   |                         | 14. USUAL OCCUPATION (Give kind of work, even if retired)<br><b>operating most of working life, even if retired heavy equip. oper.</b>                      |   |
| 15. MOTHER'S MAIDEN NAME<br><b>Amelia Funk</b>   |                         | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, give year; if no, give year or dates of service)<br><b>yes WW 2</b>                                       |   |
| 17. SOCIAL SECURITY NO.<br><b>517-10-8465</b>  |                         | 18. INFORMANT<br><b>Stover Funeral Home</b>   |   |
| 19. <b>433.9</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Cerebral Infarction</b>   |                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Epilepsy</b>  |                         | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____  |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>Epilepsy</b>  |                         |   |   |
| 20A. DATE OF OPERATION<br><b>2</b>   |                         | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |
| 21. AUTOPSY? (Yes or No)<br><b>yes</b>   |                         |   |   |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                         | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?   |                         |   |   |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)  |                         | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   |
| 22F. HOW DID INJURY OCCUR?   |                         |   |   |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D.<br>EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |                         |   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 24B. DATE<br><b>11/4/69</b>   |   |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Riverview Cem.</b>  |                         | 24D. LOCATION (City, town, or county) (State)<br><b>Strasburg, Va.</b>  |   |
| 25A. DATE BY HEALTH DEPT.<br><b>NOV 4 1969</b>   |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>   |   |
| 25C. FUNERAL DIRECTOR<br><b>Roma M. Devore</b>   |                         | ADDRESS<br><b>Baltimore</b>   |   |

80-10842

80-10842

ACADEMY

THE

69 10849 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 10849

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

LORETTA BROWN

2. DATE  
OF  
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
OR INSTITUTION ADDRESS OR LOCATION)

UNIVERSITY HOSPITAL

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

November 2, 1969

10:40 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

402

6. SEX

Female

7. RACE

Negro

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

Aug. 2, 1915

10. AGE (In years  
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

712 W. Saratoga Street

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Jerry Queen

14. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Domestic

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Maggie

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Lillian Fee 906 W. Saratoga St. Apt. 1

19. DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

Multiple Injuries

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHII  
ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

Streets

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Saratoga St. 58 ft. E. of Myrtle Avenue

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.) 11-1-69 10:40 P. m.

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Pedestrian struck by hit and run driver

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/2/69

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

Nov. 7, 1969

24C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cem.

24D. LOCATION (City, town, or county) (State)

Cedar Hill Md.

25A. DATE REC'D BY HEALTH DEPT.

NOV 4 1969

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Williams Funeral Home 3197 School St.

ADDRESS

NOT PA

1901 Ed.

72

1913

WALTER BORG

2567th 1411th

x

Walter B.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |  |                        |  |   |   |  |   |  |  |
|---|--|------------------------|--|---|---|--|---|--|--|
| BIRTH NO. <span style="font-size: 1.5em;">B-650</span> <span style="font-size: 1.5em;">69 10850</span>  |  |                        |  |   | REG. NO. <span style="font-size: 1.5em;">69 10850</span>                              |  |   |  |  |
| 1. NAME OF DECEASED<br>(Type or Print)  |  |                        |  |   | 2. DATE AND HOUR OF DEATH   |  |   |  |  |
| James O. Brown, Sr.   |  |                        |  |   | November 1, 1969   2:30 A.M.  |  |   |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  |                        |  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |  |   |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |  |                        |  |   | A. STATE B. COUNTY  |  |   |  |  |
| 31 Baltimore City Hospitals   |  |                        |  |   | Maryland Baltimore Co. 53-00  |  |   |  |  |
| C. CITY OR TOWN   |  |                        |  |   | D. INSIDE CITY LIMITS?  |  |   |  |  |
| Essex 21221   |  |                        |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |  |   |  |  |
| E. STREET AND NUMBER  |  |                        |  |   | 200 Edgewater Apartments  |  |   |  |  |
| 5. SEX  |  | 6. RACE                |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |   | 8. DATE OF BIRTH   |   | 9. AGE (In years lost birthday)                                      |  |
| Male  |  | Cau                    |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |   | Nov 30 1897  |   | 71   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  |                        |  |   | 10B. KIND OF BUSINESS OR INDUSTRY   |  |   |  |  |
| Electrician   |  |                        |  |   | Steel Mill  |  |   |  |  |
| 13. FATHER'S NAME   |  |                        |  |   | 14. MOTHER'S MAIDEN NAME  |  |   |  |  |
| Walter S. Brown   |  |                        |  |   | Mary C. Kirk  |  |   |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |  |                        |  |   | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS                       |  |  |
| Yes WWI   |  |                        |  |   | 218 03 8279   |  | James O. Brown Jr. 524 Patricia Ct. Odenton |  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |  |                        |  |   | CAUSE OF DEATH  |  |   |  |  |
| 491X I  |  |                        |  |   | Congestive Heart failure  |  |   |  |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  |  |                        |  |   | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                   |  |   |  |  |
| ANTECEDENT CAUSES   |  |                        |  |   | Pulmonary Embolism, cl. bronchitis  |  |   |  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |  |                        |  |   | (B) DUE TO, OR AS A CONSEQUENCE OF:   |  |   |  |  |
| (C) _____   |  |                        |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |                        |  |   |   |  |   |  |  |
| 19A. DATE OF OPERATION  |  |                        | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20A. AUTOPSY? (Yes or No)  |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 19A. DATE OF OPERATION  |  |                        | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20A. AUTOPSY? (Yes or No)  |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |  |                        | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |   |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |  |  |
| 21D. TIME OF INJURY (APPROX.)   |  |                        | 21E. INJURY OCCURRED   |   |   | 21F. HOW DID INJURY OCCUR?   |   |  |  |
| (Month) (Day) (Year) (Hour)   |  |                        | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |   |   | 21F. HOW DID INJURY OCCUR?   |   |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Nov 1, 1969</u> to <u>Nov 1, 1969</u> , that (I) (we) last saw the deceased alive on <u>Oct. 18, 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                        |  |   |   |  |   |  |  |
| 23A. SIGNATURE  |  |                        |  |   | 23B. DATE SIGNED  |  |   | 23C. PHYSICIAN'S NAME (Type)   |  |
| Robert Roupenoff M.D.   |  |                        |  |   | 11/3/69   |  |   | ROBERT ROUPENOFF M.D.  |  |
| 23C. PHYSICIAN'S NAME (Type)  |  |                        |  |   | 23D. ADDRESS  |  |   |  |  |
| ROBERT ROUPENOFF M.D.   |  |                        |  |   | EULLER MEDICAL GROUP RIDGE ROAD   |  |   |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |  | 24B. DATE              |  | 24C. NAME OF CEMETERY or CREMATORY  |   | 24D. LOCATION (City, town, or county) (State)                            |   |  |  |
| Burial  |  | 11/4/69                |  | New Cathedral Cemetery  |   | Baltimore, Maryland  |   |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.   |  | 25B. NAME OF REGISTRAR |  | 25C. FUNERAL DIRECTOR   |   |  | ADDRESS                                     |  |  |
| NOV 4 1969  |  | Robert E. Zuber, M.D.  |  | Funeral Home  |   |  | 1407 Eastern Ave.                           |  |  |

ALFRED HENRI

Dear Sir,  
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above matter.  
I am sorry to hear that you are not satisfied with the results of the examination.  
I have been very careful to see that all the necessary precautions were taken, and I am confident that the results are correct.  
I am, Sir, very respectfully,  
Your obedient servant,  
J. H. [Signature]



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                            |   |  | REG. NO. <b>69 10851</b>  |  |
|---|----------------------------|---|--|---|--|
| <b>BIRTH NO.</b><br><b>1. NAME OF DECEASED</b><br>(Type or Print) <b>DENA R. SILVER</b>   |                            | <b>2. DATE AND HOUR OF DEATH</b><br><b>Nov 2, 1969 9 A.M.</b>   |  |   |  |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><br><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>5000 LITCHFIELD AVE</b><br><b>00</b>  |                            | <b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution; residence before admission)<br><b>A. STATE</b> <b>MD</b> <b>B. COUNTY</b> <b>2798</b><br><b>C. CITY OR TOWN</b> <b>Balto</b> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br><b>E. STREET AND NUMBER</b> <b>5000 Litchfield Ave</b> |  |   |  |
| <b>5. SEX</b><br><b>F</b>   | <b>6. RACE</b><br><b>W</b> | <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>   |  | <b>8. DATE OF BIRTH</b><br><b>April 10, 1890</b>  | <b>9. AGE</b> (In years last birthday) <b>79</b> |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)  |                            | <b>10B. KIND OF BUSINESS OR INDUSTRY</b>  |  | <b>11. BIRTHPLACE</b> (State or foreign country) <b>Russia</b>  |  |
| <b>13. FATHER'S NAME</b><br><b>Robert</b>   |                            | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Sonia</b>   |  |   |  |
| <b>15. Was Deceased Ever in U. S. Armed Forces?</b><br>(Yes, no or unknown) (If yes, give war or dates of service)  |                            | <b>16. SOCIAL SECURITY NO.</b>  |  | <b>17. INFORMANT</b> <b>Mr. Melvin Hurwitz</b> <b>ADDRESS</b> <b>2501 Black Hawk Circle</b>   |  |
| <b>18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                            |   |  | <b>CAUSE OF DEATH</b><br><b>(A) IMMEDIATE CAUSE</b> <b>Arteriosclerotic C.V. Disease</b><br><b>DUE TO, OR AS A CONSEQUENCE OF:</b><br><b>Heart Block - Pacemaker</b><br><b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b><br><b>(C) _____</b><br><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b><br><b>2450</b><br><b>1 yr</b> |  |
| <b>II</b><br><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>  |                            |   |  |   |  |
| <b>19A. DATE OF OPERATION</b><br><b>0</b>   |                            | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>   |  | <b>20A. AUTOPSY? (Yes or No)</b><br><b>NO</b>   |  |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>   |                            | <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)   |  |
| <b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)  |                            | <b>21E. INJURY OCCURRED</b><br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | <b>21F. HOW DID INJURY OCCUR?</b>   |  |
| <b>22. I certify that (I) (this hospital) attended the deceased from 6/67 to 11/2 1969, that (I) (we) last saw the deceased alive on 11/2 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>   |                            |   |  |   |  |
| <b>23A. SIGNATURE</b><br><b>R. S. Harris</b> <b>DEGREE</b>  |                            |   |  | <b>23B. DATE SIGNED</b><br><b>11/3/69</b>   |  |
| <b>23C. PHYSICIAN'S NAME</b> (Type)   |                            |   |  | <b>23D. ADDRESS</b>   |  |
| <b>24A. BURIAL CREMATION, REMOVAL (Specify)</b><br><b>Burial</b>  |                            | <b>24B. DATE</b><br><b>Nov 3, 1969</b>  |  | <b>24C. NAME OF CEMETERY or CREMATORY</b><br><b>Druid Ridge</b>   |  |
| <b>24D. LOCATION</b> (City, town, or county) <b>Pikesville</b>  |                            | <b>24E. STATE</b> <b>MD</b>   |  |   |  |
| <b>25A. DATE REC'D BY HEALTH DEPT.</b><br><b>NOV 4 1969</b>   |                            | <b>25B. NAME OF REGISTRAR</b><br><b>Robert E. Taylor</b>  |  | <b>25C. FUNERAL DIRECTOR</b><br><b>Sylvan Lewisson</b> <b>ADDRESS</b> <b>9610 Reisterstown Rd</b>   |  |

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69 10852

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 10852

BIRTH NO. *Balte. C. No.*1. NAME OF DECEASED (Type or Print) **Raena Fredericka Meyers****Fredericka Meyers**DATE OF DEATH Known ☐ Month Day Year Hour  
Estimated ☐ **Nov. 2 1969** M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

**Johns Hopkins Hospital (DOA)**3. DATE PRONOUNCED DEAD Month Day Year Hour  
**11 2 69 12:15 P.M.**5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE **Maryland** B. COUNTY **103**

6. SEX

**Female**

7. RACE

**White**8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

**Baltimore**

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

**Sept. 12, 1969**

10. AGE (In years last birthday)

**6 wks.**

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

**1 20**

E. STREET AND NUMBER

**612 S. Rose Street**

11. BIRTHPLACE (State or foreign country)

**Maryland**

12. CITIZEN OF WHAT COUNTRY?

**USA**

13. FATHER'S NAME

**Raymond F. Meyers**

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**NONE**

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

**Anne M. Bell**

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

**NO**

17. SOCIAL SECURITY NO.

**NONE**

18. INFORMANT

ADDRESS

**Mr. Raymond F. Meyers 612 S. Rose St**

19.

CAUSE OF DEATH

**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH**

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

**Sudden death in infancy**

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

**yes**22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE  
EXAMINER'S NAME (Type)**Russell S. Fisher, M.D.**CHIEF MEDICAL EXAMINER ☒  
ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

**11-3-69**24A. BURIAL CREMATION, REMOVAL (Specify)  
**Burial**

24B. DATE

**11/4/69**

24C. NAME OF CEMETERY or CREMATORY

**Crest Lawn**

24D. LOCATION (City, town, or county) (State)

**Howard County Maryland**

25A. DATE REC'D BY HEALTH DEPT.

**NOV 4 1969**

25B. NAME OF REGISTRAR

**Robert E. Fisher, M.D.**

25C. FUNERAL DIRECTOR

**Henry Sander & Sons Inc.**

ADDRESS

**Baltimore, Maryland 21213**

BY ORDER OF THE BOARD OF DIRECTORS

ATTEST: SECRETARY

3/21

DATE: 1952

BY: [Signature]

NAME: [Name]

TO: [Name]

7224

WALTER BROWN

JOHN BROWN

BY: [Signature]

NAME: [Name]

TO: [Name]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 69 10853 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

69 10853

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Sarah I. Bishop

2. DATE AND HOUR OF DEATH

November 3, 1969

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

713 Gorsuch Avenue

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

Maryland

905

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

713 Gorsuch Avenue

5. SEX

F

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

July 16, 1889

9. AGE (In years lost birthday)

80

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Saleslady

10B. KIND OF BUSINESS OR INDUSTRY

Retired

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

George C. Bishop

14. MOTHER'S MAIDEN NAME

Adeline Caroline Hochadel

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

220

16. SOCIAL SECURITY NO.

18 9140

17. INFORMANT

2901 18th St. North West D. C. Commander G.C.B. Mears

18.

440.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

Chronic Atherosclerotic

(B) DUE TO, OR AS A CONSEQUENCE OF:

Vascular Disease

(C) DUE TO, OR AS A CONSEQUENCE OF:

Submyocardial Infarction

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

5 yr.

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

While At Work ☐

Not While At Work ☐

22. I certify that (I) (this hospital) attended the deceased from Nov - 5 - 1963 to Oct 23 - 1969, that (I) (we) last saw the deceased alive on Oct - 23 - 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.

23A. SIGNATURE

William Geyer M.D.

DEGREE

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

11/4/69

23C. PHYSICIAN'S NAME (Type)

W. M. G. GEYER

DEGREE

23D. ADDRESS

156 North Milton Avenue

24A. BURIAL CREMATION REMOVAL (Specify)

Burial

24B. DATE

11/5/69

24C. NAME OF CEMETERY or CREMATORY

Baltimore Cemetery

24D. LOCATION

Baltimore Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

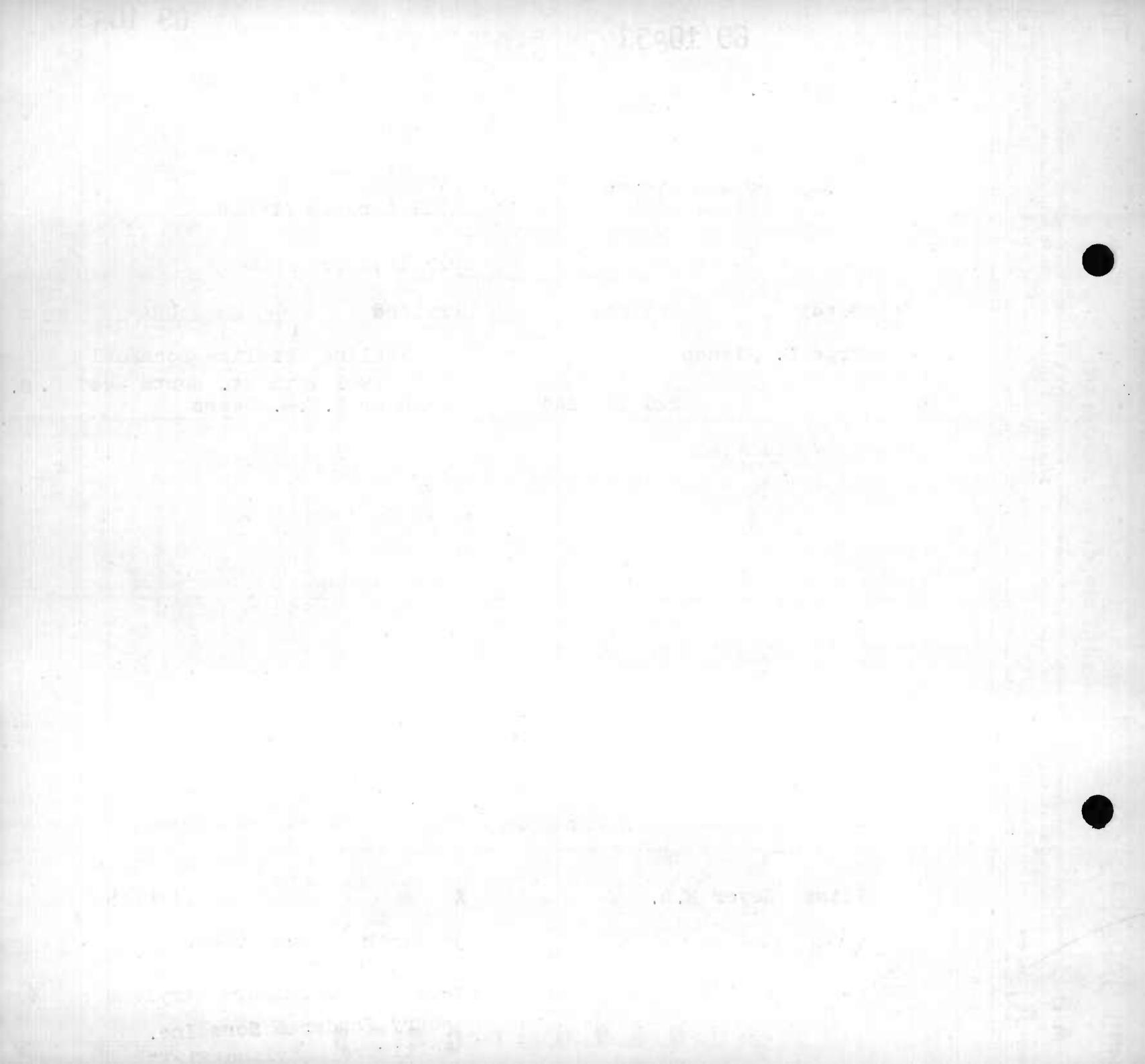
25C. FUNERAL DIRECTOR

ADDRESS

NOV 4 1969 Robert E. Valley, Jr.

Henry Sander & Sons Inc.

Baltimore Maryland 21213



C-630

69 10854 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 10854

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JAMES COWARD

2. DATE  
OF  
DEATHKnown ☐  
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
HOSPITAL ADDRESS OR LOCATION)  
OR INSTITUTION

426 Pearl Street

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

October 15, 1969

11:16 A.

M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland B. COUNTY 1701

6. SEX

Male

7. RACE

Negro

B. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

10. AGE (In years  
last birthday)

62?

If Under 1 Yr. II Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

426 Pearl Street

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

19.

412.4

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A):

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/15/69

24A. BURIAL (CREMATION),  
REMOVAL (Specify)

24B. DATE

10.31.69

24C. NAME OF CEMETERY &amp; CREMATORY

Richmond

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 4 1969

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

MORTUARY SERVICE - BCHD

22

11.3.4

WALTER BOND  
1923-1924

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |   |  |
|---|--|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. <b>69 10855</b>  |  |
| <b>E-355</b>  |  | <b>69 10855</b>   |  |
| <b>CERTIFICATE OF DEATH</b>   |  |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>EDMONDS, SALLY D</b>  |  | 2. DATE AND HOUR OF DEATH<br><b>October 30th 1969</b> <b>8<sup>45</sup> P.M.</b>  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>T/FB UNION MEMORIAL HOSPITAL</b><br><b>44</b>   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>2714</b><br>C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>ENCORE HOUSE NURSING</b><br><b>218 RIDGEWAY RD</b> |  |
| 5. SEX <b>F</b>   | 6. RACE <b>W</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <b>10-03-84</b>   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10B. KIND OF BUSINESS OR INDUSTRY   | 9. AGE (in years last birthday) <b>85</b><br>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 11. BIRTHPLACE (State or foreign country) <b>UNKNOWN</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>  |  |
| 13. FATHER'S NAME <b>FRANCES A DAVIS</b>  |  | 14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <input type="checkbox"/> yes, give war or dates of service  |  | 16. SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS  |
| 18. <b>490 X I</b> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.)<br><b>Respiratory failure -</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>ASTHMA &amp; bronchitis,</b><br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |   |  |
| 19A. DATE OF OPERATION  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20A. AUTOPSY? (Yes or No)   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (1) (this hospital) attended the deceased from <b>Oct 27</b> 19 <b>69</b> to <b>Oct 30</b> 19 <b>69</b> .<br>that (1) (we) last saw the deceased alive on <b>Oct 30</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.  |  |   |  |
| 23A. SIGNATURE <b>Tzen-chi Fan-Chiang</b> DEGREE  |  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>  | 23B. DATE SIGNED   |
| 23C. PHYSICIAN'S NAME (Type) <b>TZEN-CHI FAN-CHIANG</b> DEGREE  |  | 23D. ADDRESS <b>ANATOMY BOARD OF MARYLAND</b>   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  | 24B. DATE <b>11-13-69</b>  | 24C. NAME OF CEMETERY OR CREMATORY <b>UNIVERSITY MEDICAL SCHOOL</b>   | 24D. LOCATION (City, town, or county) (State)  |
| 25A. DATE REC'D BY HEALTH DEPT. <b>NOV 5 1969</b>   |  | 25C. FUNERAL DIRECTOR <b>MORTUARY SERVICE - BCHD</b> ADDRESS  |  |

1/6 address is 218 Ridgewood Rd. CT

THE UNITED STATES

DEPARTMENT OF JUSTICE

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

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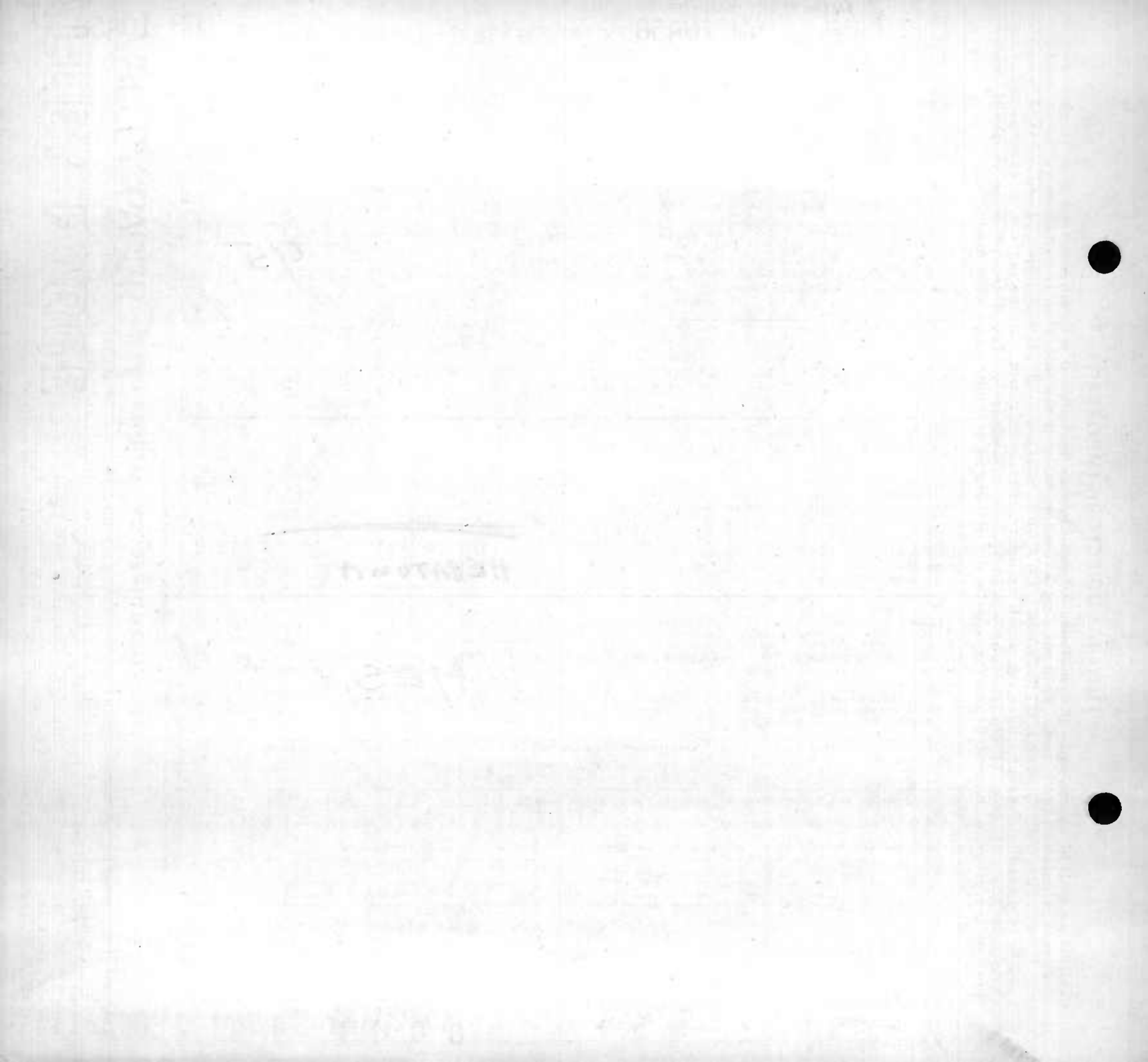
THE U.S. DEPT. OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |          |  |  |  |   |  |
|--|--|----------|--|--|--|---|--|
| J-525  |  | 69 10856 |  | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH   |  | REG. NO. 69 10856   |  |
| BIRTH NO.  |  |          |  | 2. DATE AND HOUR OF DEATH  |  |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>FREEMAN JOHNSON</u>  |  |          |  | 11-45A-M 10.29.69 M.   |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |          |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                    |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>Franklin Square Hospital</u>   |  |          |  | A. STATE <u>Baltimore</u>  |  | B. COUNTY <u>Baltimore</u>  |  |
|  |  |          |  | C. CITY OR TOWN <u>Baltimore</u>   |  | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 5. SEX <u>Male</u>   |  |          |  | 6. RACE <u>N</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>      |  |
| 8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |          |  | 9. AGE (In years last birthday) <u>95</u>  |  | 10. AGE (In years last birthday) <u>95</u>                                      |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |          |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)                                       |  |
| 12. CITIZEN OF WHAT COUNTRY?   |  |          |  | 13. FATHER'S NAME  |  |   |  |
| 14. MOTHER'S MAIDEN NAME   |  |          |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) |  |   |  |
| 16. SOCIAL SECURITY NO.  |  |          |  | 17. INFORMANT ADDRESS  |  |   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><u>155.01</u>   |  |          |  | CAUSE OF DEATH   |  |   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |  |          |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>obstructive jaundice</u>                          |  |   |  |
|  |  |          |  | (B) <u>Pancreas</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Indefinite</u>                                    |  |   |  |
|  |  |          |  | (C) <u>HEPATOMA</u>  |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |          |  |  |  |   |  |
| 19A. DATE OF OPERATION <u>2</u>  |  |          |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20. AUTOPSY? (Yes or No) <u>YES</u>   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |  |          |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)        |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |  |          |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10.15.1969</u> to <u>10.29.1969</u> , that (I) (we) last saw the deceased alive on <u>10.29.1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |          |  |  |  |   |  |
| 23A. SIGNATURE <u>[Signature]</u>  |  |          |  | 23B. DATE SIGNED   |  | 23C. PHYSICIAN'S NAME (Type) <u>ANIS F. SIDDIQI M.D.</u>                        |  |
| 24A. BURIAL CREMATION REMOVAL (Specify) <u>11-3-69</u>   |  |          |  | 24B. DATE  |  | 24C. NAME OF CEMETERY OR CREMATORY  |  |
| 25A. DATE REC'D BY HEALTH DEPT.  |  |          |  | 25B. NAME OF REGISTRAR   |  | 25C. FUNERAL DIRECTOR ADDRESS   |  |
| NOV 5 1969   |  |          |  | 25D. ADDRESS <u>ANATOMY BOARD OF MARYLAND</u>  |  | 25E. LOCATION <u>UNIVERSITY MEDICAL SCHOOL</u>                                  |  |
| VS 150-REV. 1/1/68   |  |          |  | 25F. MORTUARY SERVICE - BCHD   |  |   |  |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-523 69 10857-1

BALTIMORE CITY HEALTH DEPT. **CERTIFICATE OF DEATH** REG. NO. 69 10857

|   |                      |   |                                   |  |   |
|---|----------------------|---|-----------------------------------|--|---|
| BIRTH NO.   |                      | 1. NAME OF DECEASED<br>(Type or Print) <i>Weinstein, Rose Marie</i>   |                                   | 2. DATE AND HOUR OF DEATH<br><i>10-3-69 4:50 A.M.</i>  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><i>42 Sinai Hospital of Baltimore</i>   |                      | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <i>Maryland</i> 8. COUNTY <i>2719</i>   |                                   | C. CITY OR TOWN <i>Balto.</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>42 Sinai Hospital of Baltimore</i>   |                      | E. STREET AND NUMBER<br><i>3912 W. Northern Pkwy #15</i>  |                                   | 9. AGE (In years last birthday) <i>55</i>  |   |
| 5. SEX <i>Female</i>  | 6. RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><i>5-1-14</i> | If Under 1 Yr. Months: Days: Hours: Min.   | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Secretary</i>   |                      | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>office</i>  |                                   | 11. BIRTHPLACE (State or foreign country)<br><i>PITTS. PA.</i>   |   |
| 13. FATHER'S NAME<br><i>Jay Newman</i>  |                      | 14. MOTHER'S MAIDEN NAME<br><i>Belrose Reinstein</i>  |                                   | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                 |   |
| 16. SOCIAL SECURITY NO.<br><i>219-07-2258</i>   |                      | 17. INFORMANT<br><i>George Weinstein</i>  |                                   | ADDRESS<br><i>3912 W. Northern Parkway Apt 1-A</i>   |   |
| 18. <i>412.4 I</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                      | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br><i>Cardio-respiratory arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <i>Subarachnoid &amp; Intracerebral Hemorrhage &amp; Brainstem Compression</i><br>(C) <i>A.S.C.V.D.</i> |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>52 hrs.</i>   |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                      |   |                                   |  |   |
| 19A. DATE OF OPERATION<br><i>0</i>  |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                   | 20A. AUTOPSY? (Yes or No)  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)   |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                      | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                                   | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <i>10-1</i> 19 <i>69</i> to <i>11-3</i> 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>11-3</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                      |   |                                   |  |   |
| 23A. SIGNATURE<br><i>H. Allen M.D.</i>  |                      | 23B. DATE SIGNED<br><i>11-3-69</i>  |                                   | 23C. PHYSICIAN'S NAME (Type)<br><i>Carlos Vallin, M.D.</i>   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |                      | 24B. DATE<br><i>11-4-69</i>   |                                   | 24C. NAME OF CEMETERY OR CREMATORY<br><i>New Hope Sinai</i>  |   |
| 24D. LOCATION (City, town, or county) (State)<br><i>Harrison Forest Road, Maryland</i>  |                      | 25A. DATE REC'D BY HEALTH DEPT.<br><i>NOV 5 1969</i>  |                                   | 25B. NAME OF REGISTRAR<br><i>John E. Taber, M.D.</i>   |   |
| 25C. FUNERAL DIRECTOR<br><i>John E. Taber, M.D.</i>   |                      | 25D. ADDRESS<br><i>6010 Ruston Rd</i>   |                                   | 25E. ADDRESS<br><i>6010 Ruston Rd</i>  |   |

11-3-11  
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11-3-11

Green Hospital of Boston 312 W. North Street  
2-1-14 22

Resident 1712 W. North Street  
11-3-11

Radio-therapeutic 22  
11-3-11

Subcutaneous 22  
11-3-11

11-3-11

11-3-11

11-3-11

Green Hospital of Boston  
11-3-11

11-3-11

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department   |                         |   |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. 69 10858  |  |
|--|-------------------------|---|--|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>MILLER, ANNA LOUISE</b>  |                         |   |  | 2. DATE AND HOUR OF DEATH<br><b>11/2/69</b> <b>11:05 A M.</b>   |  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>90 JEWISH CONVELESANT HOME</b>   |                         |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>2730</b><br>C. CITY OR TOWN <b>BALTIMORE</b><br>D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>E. STREET AND NUMBER <b>3009 FALLSTAFF MANOR CT. APT. E #09</b> |  |  |  |
| 5. SEX<br><b>FEMALE</b>  | 6. RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5/10/63</b>   | 9. AGE (In years last birthday)<br><b>66</b>  | If Under 1 Yr. Months: Days: Hours: Min.                           | If Under 24 Hrs. Hours: Min.   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b> |
| 11. BIRTHPLACE (State or foreign country)<br><b>HOT SPRINGS, ARKANSAS</b>  |                         |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |  |  |  |
| 13. FATHER'S NAME<br><b>MAX KRISS</b>  |                         |   | 14. MOTHER'S MAIDEN NAME<br><b>HANNAH ?</b>  |   |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>  |                         |   | 16. SOCIAL SECURITY NO.<br><b>215-34-0123A</b>   |   | 17. INFORMANT<br><b>MR. DAVID MILLER, 3009 FALLSTAFF MANOR CT.</b> |  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>CEREBROVASCULAR ACCIDENT</b>  |                         |   | CAUSE OF DEATH<br><b>CEREBROVASCULAR ACCIDENT</b>  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Approx. 7 MONTHS</b>            |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                         |   | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>LONG STANDING CEREBROVASCULAR DISEASE</b> |   |  |  |  |
|  |                         |   | (B) DUE TO, OR AS A CONSEQUENCE OF:  |   |  |  |  |
|  |                         |   | (C) DUE TO, OR AS A CONSEQUENCE OF:  |   |  |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>ARTERIO-SCLEROTIC C.V.D.</b>  |                         |   |  |   |  |  |  |
| 19A. DATE OF OPERATION<br><b>11-2-69</b>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?               |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>11-2-1969</b> to <b>11-2-1969</b> , that (I) (we) last saw the deceased alive on <b>11-2-1969</b> and that in (my) (our) opinion death occurred on the date <b>11-2-1969</b> and from the causes stated above (I) (We) (did) (did not) view the body after death. |                         |   |  |   |  |  |  |
| 23A. SIGNATURE<br><b>Joseph Deckerbaum</b>   |                         |   |  | 23B. DATE SIGNED<br><b>11-2-69</b>  |  |  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>JOSEPH DECKERBAUM, M.D.</b>   |                         |   |  | 23D. ADDRESS<br><b>3502 WEST ROGERS AVE. BALTO. MD. 21215</b>   |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                         | 24B. DATE<br><b>11-4-69</b>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>CHITZUK AMUNO</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>W. ROGERS AVENUE, MARYLAND</b> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 5 1969</b>   |                         | 25B. NAME OF REGISTRAR<br><b>D. E. E. F. B. R.</b>  |  | 25C. FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN RD.</b>   |  |  |  |

*Handwritten signature*  
Jesse Greenbaum, M.D.

Formal - 11-6-69 - 0020 1000

300 West 10th St. Suite 10  
11-5-69

11-2-69

11-2-69

Large standing copper structure  
Diameter

Copper structure, 6' dia.

215-24-01234 10' WATER MILLER, 2000 INCHES AND 1000

1000

AT HOME

1000

NOTE

1000



69 10859

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 10859

BIRTH NO.

|  |  |  |  |
|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>WAYNE</b><br><b>Larry Brosman</b>  |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> Month Day Year<br>Hour   |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>42 Sinai Hospital</b>   |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>11 2 69 4:30 P.M.</b>   |  |
| 6. SEX<br><b>Male</b>  |  | 7. RACE<br><b>White</b>  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>53-00</b>  |  |
| 9. DATE OF BIRTH<br><b>8-18-56</b>   |  | 10. AGE (In years last birthday) <b>13</b><br>If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>WHITE PLAINS, N.Y.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>STUDENT</b>  |  | 14B. KIND OF BUSINESS OR INDUSTRY<br><b>SCHOOL</b>   |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |  | 17. SOCIAL SECURITY NO.  |  |
| 19. <b>E 814.7</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |  | CAUSE OF DEATH<br><b>Fracture of cervical spine.</b><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) DUE TO, OR AS A CONSEQUENCE OF: |  |
| 20A. DATE OF OPERATION   |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>street</b>  |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br><b>Park Heights Ave. 36' N. of Ridge Rd.</b>   |  | 22F. HOW DID INJURY OCCUR?<br><b>Pedestrian struck by car.</b>   |  |
| 22D. TIME OF INJURY (APPROX.)<br>10 31 69 7:10 P.  |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br><br>ACTUAL SIGNATURE <b>Russell S. Fisher</b> M.D.<br>EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b><br><br>CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br><br>DATE SIGNED <b>11-3-69</b> |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 24B. DATE<br><b>11-4-69</b>  |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>BETH TFILOH</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>WINDSOR MILL ROAD, MARYLAND</b>  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 5 1969</b>   |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher, M.D.</b>  |  |
| 25C. FUNERAL DIRECTOR<br><b>SAL LEVINSON &amp; BROS.</b>   |  | ADDRESS<br><b>6010 REISTERSTOWN RD.</b>  |  |

02201 03

STATION

4-11-54

STATE DEPARTMENT  
FEDERAL BUREAU OF INVESTIGATION

USA  
SCHOOL

WHITE PLAINS, N.Y.  
STUDENT

RE: WHITE BROTHERS, SIOB WAMAT ROAD, WHITE

NO

MAILED  
APR 11 1954

WITNESS WILL COME AT 11:00

WITH FELLOW

11-4-54

CRIMINAL

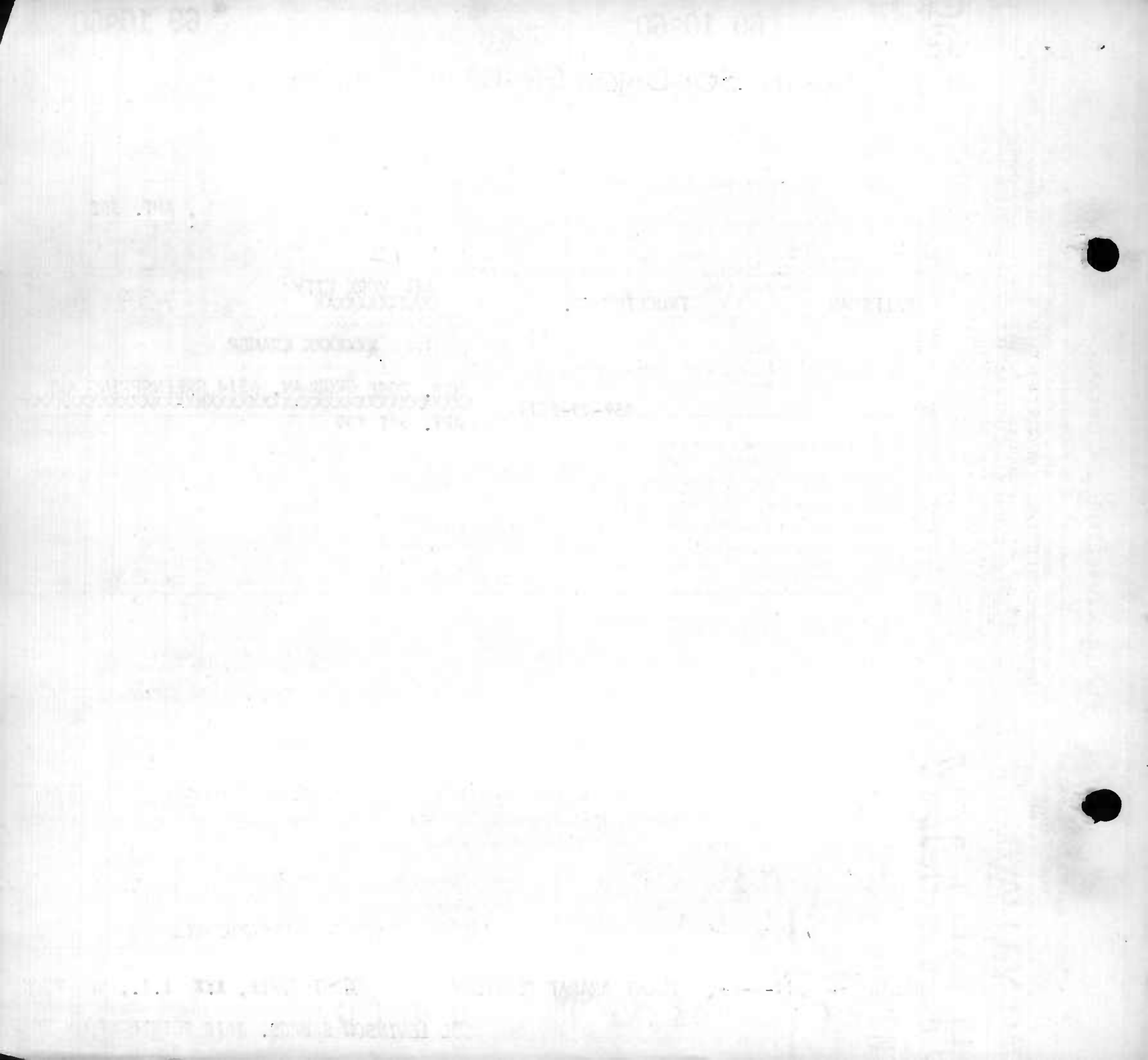
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5970, 5980, 5990, 6000, 6010, 6020, 6030, 6040, 6050, 6060, 6070, 6080, 6090, 6100, 6110, 6120, 6130, 6140, 6150, 6160, 6170, 6180, 6190, 6200, 6210, 6220, 6230, 6240, 6250, 6260, 6270, 6280, 6290, 6300, 6310, 6320, 6330, 6340, 6350, 6360, 6370, 6380, 6390, 6400, 6410, 6420, 6430, 6440, 6450, 6460, 6470, 6480, 6490, 6500, 6510, 6520, 6530, 6540, 6550, 6560, 6570, 6580, 6590, 6600, 6610, 6620, 6630, 6640, 6650, 6660, 6670, 6680, 6690, 6700, 6710, 6720, 6730, 6740, 6750, 6760, 6770, 6780, 6790, 6800, 6810, 6820, 6830, 6840, 6850, 6860, 6870, 6880, 6890, 6900, 6910, 6920, 6930, 6940, 6950, 6960, 6970, 6980, 6990, 7000, 7010, 7020, 7030, 7040, 7050, 7060, 7070, 7080, 7090, 7100, 7110, 7120, 7130, 7140, 7150, 7160, 7170, 7180, 7190, 7200, 7210, 7220, 7230, 7240, 7250, 7260, 7270, 7280, 7290, 7300, 7310, 7320, 7330, 7340, 7350, 7360, 7370, 7380, 7390, 7400, 7410, 7420, 7430, 7440, 7450, 7460, 7470, 7480, 7490, 7500, 7510, 7520, 7530, 7540, 7550, 7560, 7570, 7580, 7590, 7600, 7610, 7620, 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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

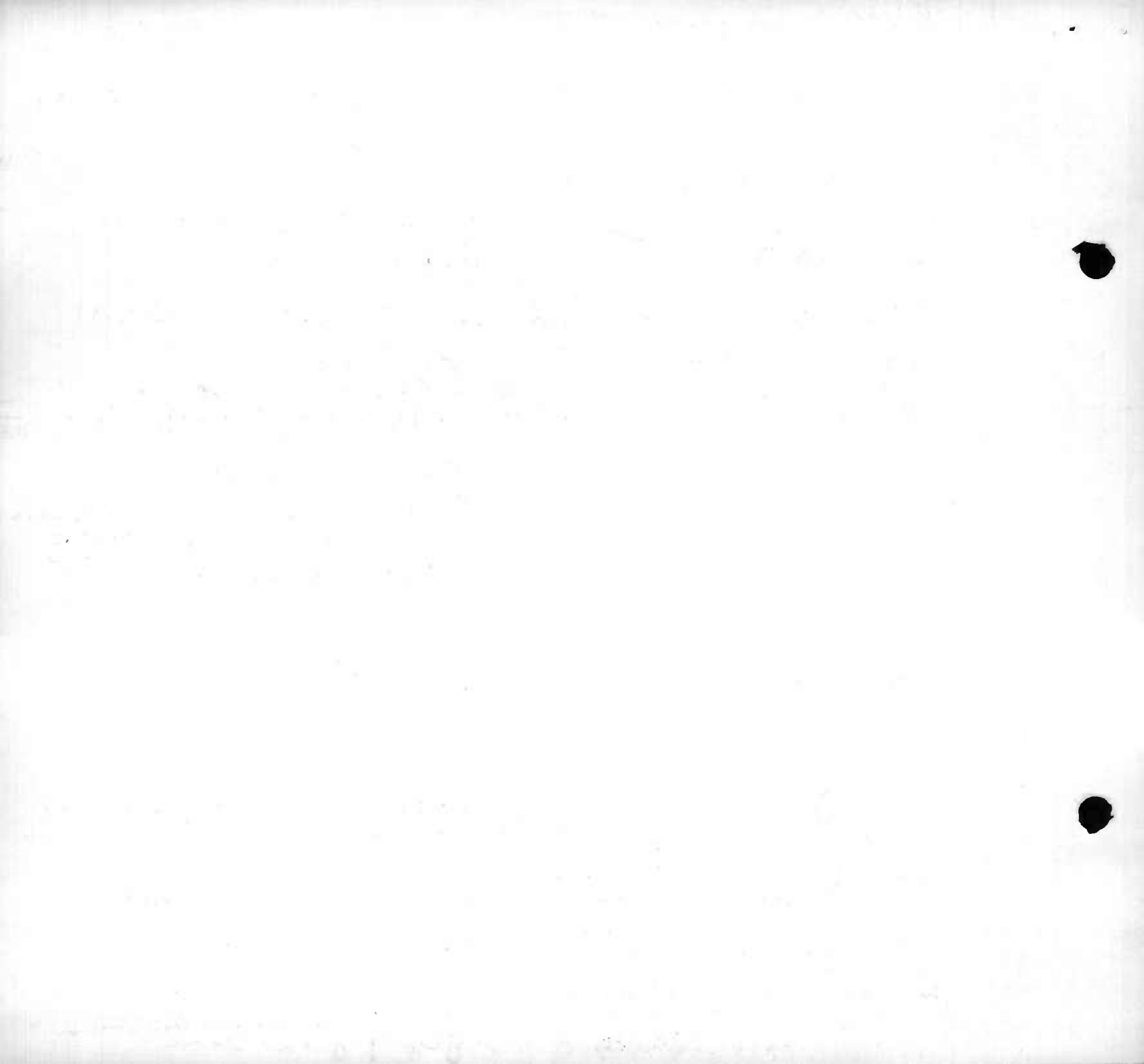
|  |                         |  |                                      |
|--|-------------------------|--|--------------------------------------|
| <div style="display: flex; justify-content: space-between;"> <span><b>G-615</b></span> <span><b>69 10860</b></span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <div style="text-align: center;"> <b>CERTIFICATE OF DEATH</b> </div>  |                         | REG. NO. <b>69 10860</b>   |                                      |
| BIRTH NO. _____  |                         | 1. NAME OF DECEASED<br>(Type or Print) <b>FRANK SOLOMON GRUBMAN</b>  |                                      |
| 2. DATE AND HOUR OF DEATH<br><b>11/3/69 125 AM</b>   |                         | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><b>JOHNS HOPKINS HOSPITAL</b>  |                                      |
| 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b>   |                         | 5. CITY OR TOWN <b>Baltimore</b>   |                                      |
| 6. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                         | 7. STREET AND NUMBER<br><b>6314 Green Spring Ave., APT. 302</b>  |                                      |
| 8. SEX<br><b>Male</b>  | 9. RACE<br><b>White</b> | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 11. DATE OF BIRTH<br><b>10/19/42</b> |
| 12. AGE (In years lost birthday) <b>57</b>   |                         | 13. IF Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.  |                                      |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>SALESMAN</b>  |                         | 15. KIND OF BUSINESS OR INDUSTRY<br><b>TRUCKING CO.</b>  |                                      |
| 16. BIRTHPLACE (State or foreign country)<br><b>NEW YORK CITY</b>  |                         | 17. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                      |
| 18. FATHER'S NAME<br><b>Isadore Grubman</b>  |                         | 19. MOTHER'S MAIDEN NAME<br><b>Rose KRAMER</b>   |                                      |
| 20. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>  |                         | 21. SOCIAL SECURITY NO.<br><b>059-09-0311</b>  |                                      |
| 22. INFORMANT<br><b>MRS. ROSE GRUBMAN</b>  |                         | 23. ADDRESS<br><b>6314 GREENSPRING AVE</b>   |                                      |
| 24. CAUSE OF DEATH<br><b>403 X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>acute bronchopneumonia/amyloid.</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>uremia</b><br><b>hepato-renal</b> |                         |  |                                      |
| 25. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                         |  |                                      |
| 26. DATE OF OPERATION<br><b>0</b>  |                         | 27. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                      |
| 28. AUTOPSY? (Yes or No)<br><b>NO</b>  |                         | 29. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                                      |
| 30. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |                         | 31. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                      |
| 32. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                         | 33. TIME OF INJURY (Month) (Day) (Year) (Hour)   |                                      |
| 34. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                         | 35. HOW DID INJURY OCCUR?  |                                      |
| 36. I certify that (I) (this hospital) attended the deceased from <b>10/11/69</b> to <b>11/3/69</b> and that (I) (we) lost saw the deceased alive on <b>11/2/69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> (did not) view the body after death.  |                         |  |                                      |
| 37. SIGNATURE<br><b>Thomas Inui MD</b>   |                         | 38. DATE SIGNED<br><b>11/3/69</b>  |                                      |
| 39. PHYSICIAN'S NAME (Type)<br><b>THOMAS INUI</b>  |                         | 40. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>   |                                      |
| 41. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                         | 42. DATE<br><b>11-4-69</b>   |                                      |
| 43. NAME of CEMETERY or CREMATORY<br><b>MOUNT ARARAT CEMETERY</b>  |                         | 44. LOCATION (City, town, or county) (State)<br><b>FARMINGDALE, XXX L.I., NEW YORK</b>   |                                      |
| 45. DATE REC'D BY HEALTH DEPT.<br><b>NOV 5 1969</b>  |                         | 46. NAME OF REGISTRAR<br><b>John E. Taylor, M.D.</b>   |                                      |
| 47. FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BROS.</b>  |                         | 48. ADDRESS<br><b>6010 REISTERSTOWN ROAD</b>   |                                      |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |   |  |
|--|--|---|--|
| <p><b>P-420</b>      <b>69 10861</b>      <b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p style="text-align: center;"><b>CERTIFICATE OF DEATH</b></p>   |  | <p>REG. NO. <b>69 10861</b></p>   |  |
| <p><b>BIRTH NO.</b> <b>P-420</b></p>   |  | <p><b>2. DATE AND HOUR OF DEATH</b><br/>11/1/69 12 20 PM.</p>   |  |
| <p><b>1. NAME OF DECEASED</b><br/>(Type or Print) <b>Alexander Pollack</b></p>   |  | <p><b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission)<br/>A. STATE <b>Maryland</b> B. COUNTY <b>2720</b></p>  |  |
| <p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br/>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br/><b>42 Sinai Hospital Inc.</b></p>   |  | <p><b>C. CITY OR TOWN</b> <b>Balto.</b> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>   |  |
| <p><b>5. SEX</b> <b>Male</b> <b>6. RACE</b> <b>White</b> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>   |  | <p><b>8. DATE OF BIRTH</b> <b>1/30/1900</b> <b>9. AGE</b> (in years last birthday) <b>69</b> <b>10. UNDER 1 Yr. Months</b> <b>11. UNDER 24 Hrs. Days</b></p>  |  |
| <p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Plumber</b> <b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>Building</b></p>  |  | <p><b>11. BIRTHPLACE</b> (State or foreign country) <b>Balto. Md.</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b></p>   |  |
| <p><b>13. FATHER'S NAME</b> <b>Meyer Pollack</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Hannah Paul</b></p>  |  | <p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b> <b>16. SOCIAL SECURITY NO.</b> <b>218-03-7928</b> <b>17. INFORMATION</b> <b>Hilda Pollack - (Personal shut down)</b> <b>ADDRESS</b> <b>#15 4002 GLENGYLE AVE</b></p> |  |
| <p><b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br/>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br/><b>1. 1561 I</b><br/><b>Pulmonary edema</b><br/><b>Cardiac Arrest</b></p>                               |  | <p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b><br/><b>Surge was 14 mos ago</b></p>  |  |
| <p><b>ANTECEDENT CAUSES</b><br/>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br/><b>II</b><br/><b>Carcinoma of common duct with metast.</b></p>   |  | <p><b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b><br/><b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b><br/><b>(C)</b></p>   |  |
| <p><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b></p>   |  |   |  |
| <p><b>19A. DATE OF OPERATION</b> <b>14 mos ago</b> <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>Carcinoma of common duct</b></p>   |  | <p><b>20A. AUTOPSY?</b> (Yes or No) <input checked="" type="checkbox"/> <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>   |  |
| <p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/></p>   |  | <p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>  |  |
| <p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.) <b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>  |  | <p><b>21F. HOW DID INJURY OCCUR?</b></p>  |  |
| <p><b>22. I certify that (1) (this hospital) attended the deceased from 10/26/1969 to 11/1/1969 that (1) (we) last saw the deceased alive on 10/31/1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.</b></p> |  |   |  |
| <p><b>23A. SIGNATURE</b> <b>Samuel J. Abrams</b> <b>DEGREE</b> <b>MD</b></p>   |  | <p><b>23B. DATE SIGNED</b> <b>11/1/69</b></p>   |  |
| <p><b>23C. PHYSICIAN'S NAME</b> (Type) <b>Samuel J. Abrams</b> <b>DEGREE</b> <b>MD</b></p>   |  | <p><b>23D. ADDRESS</b> <b>7220 Park Heights Ave</b></p>   |  |
| <p><b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b> <b>24B. DATE</b> <b>11/2/69</b></p>   |  | <p><b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>Workmen's Circle</b> <b>24D. LOCATION</b> (City, town, or county) <b>Balto. Md.</b> (State)</p>   |  |
| <p><b>25A. DATE REGISTERED</b> <b>NOV 5 1969</b> <b>25B. NAME OF REGISTRAR</b> <b>Samuel J. Abrams</b></p>   |  | <p><b>25C. FUNERAL DIRECTOR</b> <b>6010 Registration</b> <b>ADDRESS</b> <b>1500</b></p>   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |   |  |  | REG. NO. <b>69 10862</b>   |
|---|---|--|--|--|
| 0-250 69 10862  |   | <b>CERTIFICATE OF DEATH</b>  |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Jacob W. OKUM</b>   |   | 2. DATE AND HOUR OF DEATH<br><b>October 31, 1969 12:01 A. M.</b>   |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>90 PLEASANT MANOR NURSING HOME</b>  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>BALTIMORE</b><br>C. CITY OR TOWN <b>BALTIMORE</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>3918 EMMART AVENUE #21215</b> |  |  |
| 5. SEX<br><b>MALE</b>   | 6. RACE<br><b>WHITE</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>11-19-07</b>                                  | 9. AGE (In years last birthday) <b>61</b>  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>SALESMAN</b>  |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>RETAIL</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>PHILADELPHIA, PA.</b>              |
| 13. FATHER'S NAME<br><b>MORRIS OKUM</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>LENA COOPERSTEIN</b>  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>YES NAVY WW II</b>   |   | 16. SOCIAL SECURITY NO.<br><b>577-09-5639</b>  |  | 17. INFORMANT<br><b>MRS. MINNIE OKUM, 3918 EMMART AVENUE #15</b>                   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>1890 I</b><br><b>CAUSE OF DEATH</b><br><b>METASTATIC CARCINOMA (HYPERNEPHROMA)</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b> |   | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) DUE TO, OR AS A CONSEQUENCE OF:   |  |  |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |   |  |  |  |
| 19A. DATE OF OPERATION  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20A. AUTOPSY? (Yes or No)<br><b>No</b>   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Mar. 2 1969</b> to <b>10/31 1969</b> , that (I) (we) lost saw the deceased alive on <b>10/29 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                     |   |  |  |  |
| 23A. SIGNATURE<br><b>Joseph S. Blum</b>   |   | 23B. DATE SIGNED<br><b>10/31/69</b>  |  | 23C. PHYSICIAN'S NAME (Type)<br><b>JOSEPH S. BLUM MD</b>                           |
| 23D. ADDRESS<br><b>1115 N. CALVERT ST</b>   |   | 24. LOCATION (City, town, or county) (State)<br><b>WASHINGTON BLVD., MARYLAND</b>  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 24B. DATE<br><b>11-2-69</b>   | 24C. NAME OF CEMETERY or CREMATORY<br><b>MOSES MONTIFILORE</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>WASHINGTON BLVD., MARYLAND</b> |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 5 1969</b>  |   | 25B. NAME OF REGISTRAR<br><b>Robert E. Blum, MD</b>  |  | 25C. FUNERAL DIRECTOR<br><b>John E. Brown, 6010 Rustentown Rd.</b>                 |

COPIES

JACK

1913-1914  
1913-1914

1913-1914

WHITE

1913-1914

1913-1914

1913-1914

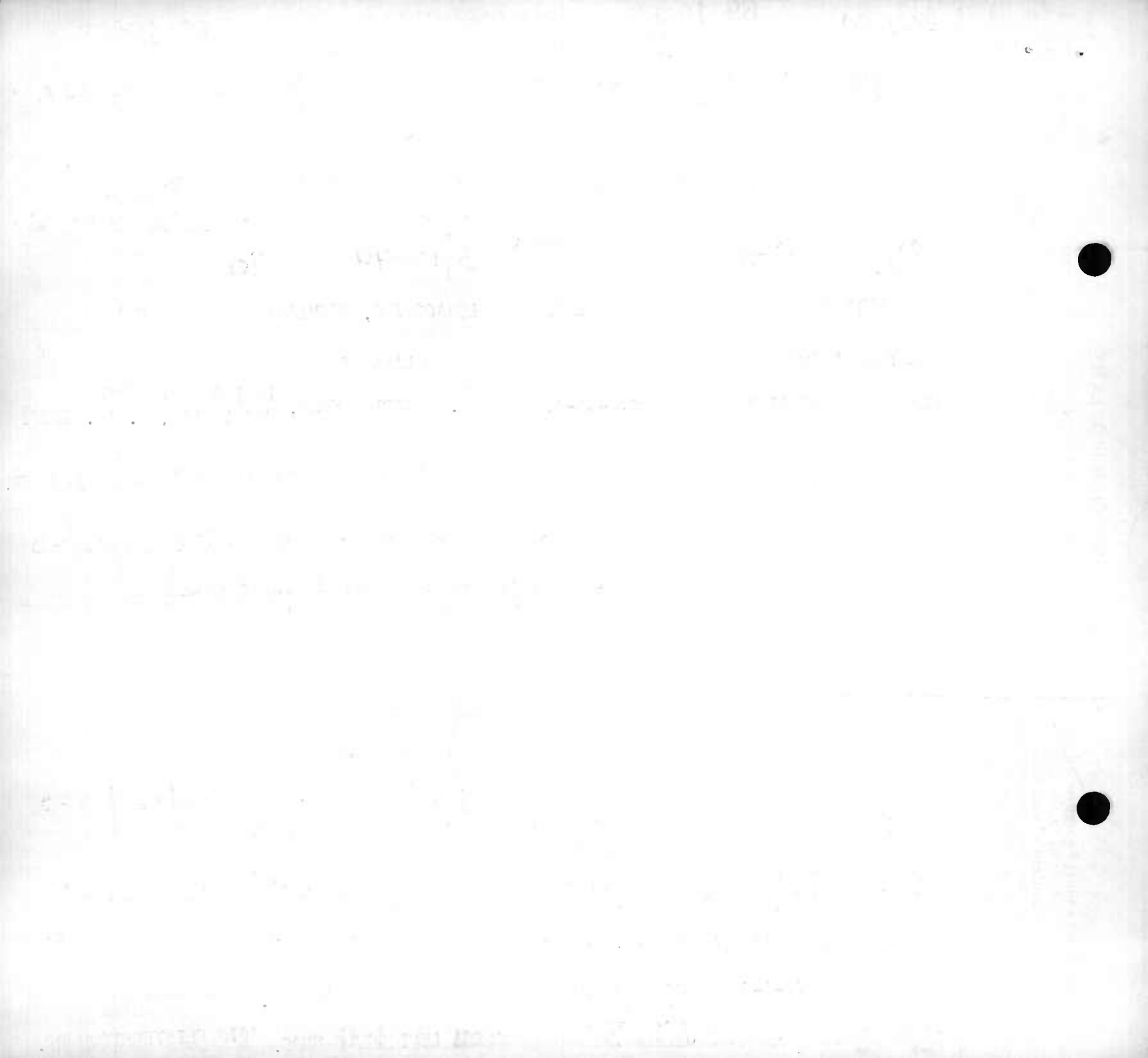
1913-1914

1913-1914

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH  |                             |   |                                    | REG. NO. <b>69 10863</b>  |
|---|-----------------------------|---|------------------------------------|---|
| BIRTH NO. <b>4-620</b>  |                             | 69 10863 <b>I.</b>  |                                    |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>DR MYRON PRICE</b>  |                             | 2. DATE AND HOUR OF DEATH<br><b>10/30/69 10:25 P.M.</b>   |                                    |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                             | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD</b> B. COUNTY <b>2719</b>                           |                                    |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>SINAI HOSPITAL OF BALTIMORE, INC.</b>  |                             | C. CITY OR TOWN<br><b>BALTIMORE</b>   |                                    | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| E. STREET AND NUMBER<br><b>4200 WEST NORTHERN PARKWAY</b>   |                             |   |                                    |   |
| 5. SEX<br><b>MALE</b>   | 6. RACE<br><b>WHITE</b>     | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5/12/99</b> | 9. AGE (In years last birthday) <b>70</b>   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>DENTIST</b>   |                             | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>SELF EMPLOYED</b>   |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>LONA CONING, MARYLAND</b>                     |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                             |   |                                    |   |
| 13. FATHER'S NAME<br><b>ARTHUR PRICE</b>  |                             | 14. MOTHER'S MAIDEN NAME<br><b>CLARA ?</b>  |                                    |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>YES WW II ARMY</b>   |                             | 16. SOCIAL SECURITY NO.<br><b>214-38-6855A</b>  |                                    | 17. INFORMANT<br><b>MRS. BEATRICE HESS, 1401 SUMMIT DRIVE, CHARLESTON, W. VA. 25302</b>       |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>UREMIA - PNEUMONIA</b>   |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10/9/69</b>  |                                    |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>RENAL FAILURE - ASCVD WITH CONGESTIVE HEART FAILURE</b>  |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10/30/69</b>   |                                    |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |                             |   |                                    |   |
| 19A. DATE OF OPERATION<br><b>0</b>  |                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                    | 20A. AUTOPSY? (Yes or No)   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                             | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                                    | 21F. HOW DID INJURY OCCUR?  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10/5/69</b> to <b>10/30/69</b> that (I) (we) last saw the deceased alive on <b>10/30/69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                             |   |                                    |   |
| 23A. SIGNATURE<br><b>Peter Papastamoy, M.D.</b>   |                             | 23B. DATE SIGNED<br><b>10/30/69</b>   |                                    |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>PETER PAPA STAMOY, M.D.</b>  |                             | 23D. ADDRESS<br><b>SINAI HOSPITAL OF BALTIMORE</b>  |                                    |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 24B. DATE<br><b>11-2-69</b> | 24C. NAME OF CEMETERY OR CREMATORY<br><b>BNAI ISRAEL</b>  |                                    | 24D. LOCATION (City, town, or county) (State)<br><b>CHARLESTON, WEST VIRGINIA</b>             |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 5 1969</b>  |                             | 25B. NAME OF REGISTRAR<br><b>John E. Bailey, R.A.</b>   |                                    | 25C. FUNERAL DIRECTOR<br><b>SOB LEVINSON &amp; BROS. 6010 REISTERSTOWN RD.</b>                |





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                  |   |   |   |  |   |  |          |  |
|--|------------------|---|---|---|--|---|--|----------|--|
| G-625  |                  | 69 10864  |   | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO.  |  | 69 10864 |  |
| BIRTH NO.  |                  | 1. NAME OF DECEASED<br>(Type or Print)  |   |   |  | 2. DATE AND HOUR OF DEATH   |  |          |  |
|  |                  | HYMAN GROSSMAN  |   |   |  | 10/31/69 9:40 P.M.  |  |          |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)   |   |   |  |   |  |          |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |                  | A. STATE<br>Md. USA   |   |   |  | B. COUNTY<br>2717   |  |          |  |
| 42 Sinai Hosp. of Baltimore<br>Belvedere Ave. at Green Spring  |                  | C. CITY OR TOWN<br>Baltimore  |   |   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |          |  |
| E. STREET AND NUMBER<br>2706 Uhler Ave #15   |                  |   |   |   |  |   |  |          |  |
| 5. SEX<br>Male   | 6. RACE<br>White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                 | 8. DATE OF BIRTH<br>6/4/91                | 9. AGE (In years last birthday)<br>78                                       | If Under 1 Yr. Months: Days: Hours: Min. |   |  |          |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Salesman  |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>Retail   |   | 11. BIRTHPLACE (State or foreign country)<br>Russia                         |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA   |  |          |  |
| 13. FATHER'S NAME<br>Abraham Grossman  |                  |   | 14. MOTHER'S MAIDEN NAME<br>Chana Shifra? |   |  |   |  |          |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No   |                  | 16. SOCIAL SECURITY NO.<br>218-10-2094  |   | 17. INFORMANT<br>Mr. Mike Reich   |  | ADDRESS<br>3225 Southgreen Rd   |  |          |  |
| 18. 412.41<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>Subarachnoid hemorrhage<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) Atherosclerotic Cardiovascular disease<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |          |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |                  |   |   |   |  |   |  |          |  |
| 19A. DATE OF OPERATION<br>D  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |          |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location) |  |   |  |          |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |   | 21F. HOW DID INJURY OCCUR?  |  |   |  |          |  |
| 22. I certify that (He) (this hospital) attended the deceased from 10/18 1969 to 10/31 1969<br>that (He) (we) lost saw the deceased alive on 10/31 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (He) (We) (did) (did not) view the body after death.                              |                  |   |   |   |  |   |  |          |  |
| 23A. SIGNATURE<br>JOSE F. CALIMLIN, JR. MD.  |                  | 23B. DATE SIGNED<br>10/31/69  |   | 23C. PHYSICIAN'S NAME (Type)<br>JOSE F. CALIMLIN, JR. MD.                   |  | 23D. ADDRESS<br>Sinai Hospital  |  |          |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial   |                  | 24B. DATE<br>Nov 2/69   |   | 24C. NAME OF CEMETERY OR CREMATORY<br>Tiberth Mount Oak Hill                |  | 24D. LOCATION (City, town, or county) (State)<br>Keddale, Maryland                            |  |          |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 5 1969  |                  | 25B. NAME OF REGISTRAR<br>J. E. J. J.   |   | 25C. FUNERAL DIRECTOR<br>Solomonson Inc                                     |  | 25D. ADDRESS<br>6010 Reisterstown Rd  |  |          |  |



1  
S-245 69 10865 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 69 10865

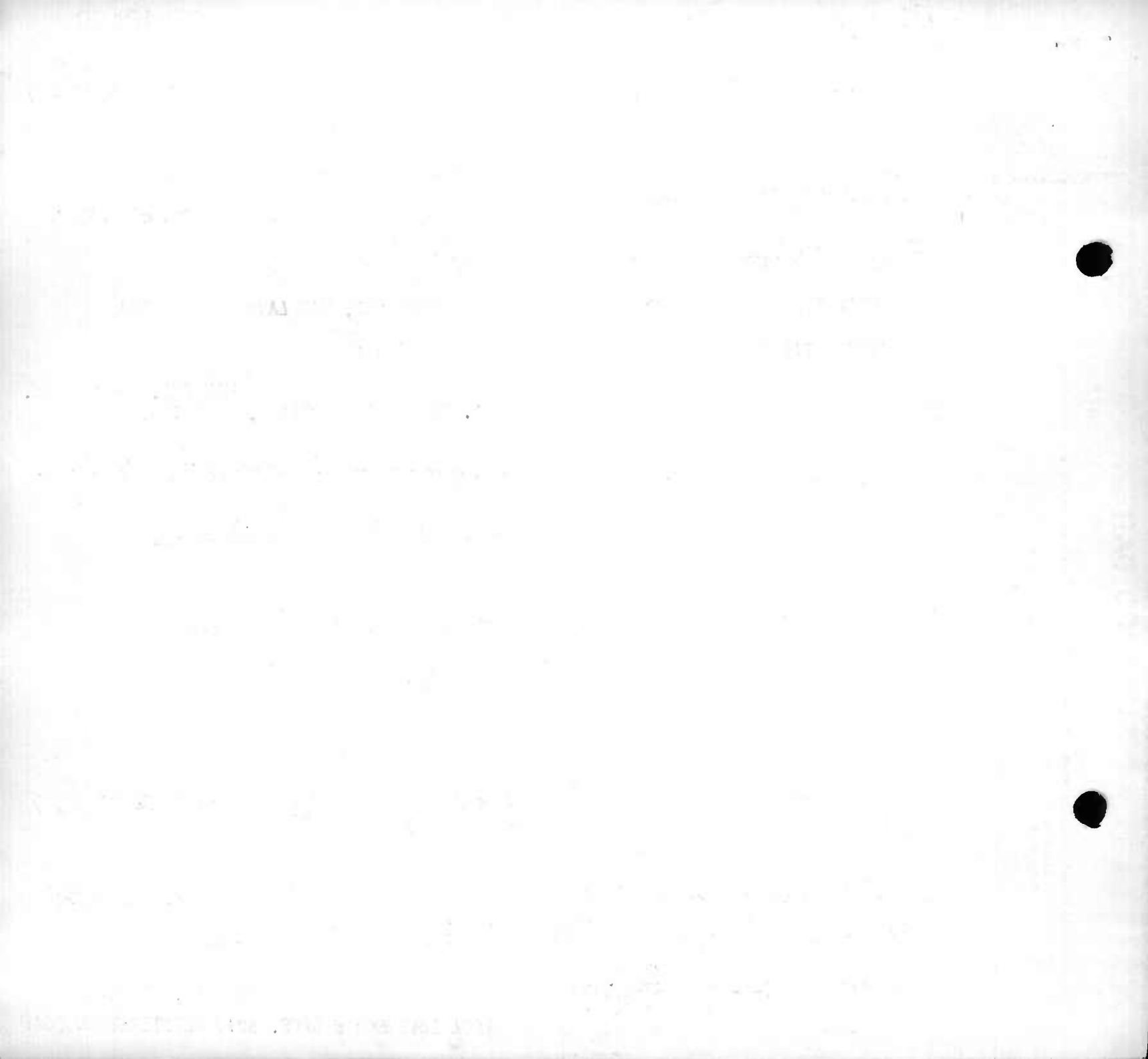
|  |  |  |  |   |  |
|--|--|--|--|---|--|
| BIRTH NO.  |  | 1. NAME OF DECEASED<br>(Type or Print) MEYER <del>MEYER</del> SISSELMAN  |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> M.           |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>MARYLAND GENERAL HOSPITAL (DOA)  |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br>October 31, 1969 3:40 P.M.   |  | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland B. COUNTY 1102 |  |
| 6. SEX<br>Male   | 7. RACE<br>White                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | C. CITY OR TOWN<br>Baltimore                               |   | D. INSIDE CITY LIMITS<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 9. DATE OF BIRTH<br>Feb 12, 1923   | 10. AGE (In years last birthday)<br>46 | If Under 1 Yr. If Under 24 Hrs.<br>Months Days Hours Min.  | E. STREET AND NUMBER<br>212 W. Monument Street, Room 406A  |   |  |
| 11. BIRTHPLACE (State or foreign country)<br>Balto, Md   |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 13. FATHER'S NAME<br>Morris Sisselman                      |   |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Employee  |  | 14B. KIND OF BUSINESS OR INDUSTRY<br>B&O Railroad  | 15. MOTHER'S MAIDEN NAME<br>Ray Fine                       |   |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  |  | 17. SOCIAL SECURITY NO.<br>215-18-3218   | 18. INFORMANT<br>Mrs. Sarah Hayden 4103 Shotten Lane 21213 |   |  |
| 19. CAUSE OF DEATH<br>E950.0<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>Overdose of barbiturate<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |  |  |  |   |  |
| 20A. DATE OF OPERATION<br>2  |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 21. AUTOPSY? (Yes or No)<br>yes  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>Home   |  | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>212 W. Monument Street 11-02                  |  |
| 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)<br>Oct. 1969 Unk.  |  | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                |  | 22F. HOW DID INJURY OCCUR?<br>Subj. ingested Overdose of barbiturate  |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.<br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED 11/1/69 |  |  |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial   |  | 24B. DATE<br>11/2/69   | 24C. NAME OF CEMETERY or CREMATORY<br>Balto Hebrew         |   | 24D. LOCATION (City, town, or county) (State)<br>2100 Belair Rd. Balto, Md.                  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 5 1969  |  | 25B. NAME OF REGISTRAR<br>Robert E. Taylor, Jr.  |  | 25C. FUNERAL DIRECTOR<br>Sol Lewin & Sons Inc. 6010 Reister Rd.   |  |

VS 177 by Dr. Kornblum. ~~xxxxxx~~

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |  |  |
|--|--|--|--|
| BALTIMORE CITY HEALTH DEPARTMENT   |  | REG. NO. 69 10866  |  |
| A-346 69 10866   |  | CERTIFICATE OF DEATH   |  |
| BIRTH NO.  |  | 2. DATE AND HOUR OF DEATH  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>SYDEL ADLER SARAH</u>  |  | <u>4:32 AM NOV. 2, 1969</u>  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>42 SINAI HOSPITAL</u>   |  | A. STATE <u>MD.</u> B. COUNTY <u>BALT.</u>   |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |  | C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                              |  |
|  |  | E. STREET AND NUMBER <u>5454 LYNVIEW AVE #15</u>   |  |
| 5. SEX <u>FEMALE</u>   | 6. RACE <u>WHITE</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/21/97</u>  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>   |  | 10B. KIND OF BUSINESS OR INDUSTRY <u>ATHOME</u>  | 9. AGE (in years last birthday) <u>72</u>  |
| 11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |
| 13. FATHER'S NAME <u>NATHAN MILLER</u>   |  | 14. MOTHER'S MAIDEN NAME <u>LENA ?</u>   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>   |  | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT <u>MR. JEROME JACK MILLER, #21207</u>  |  | ADDRESS <u>BOX 505, Dogwood Rd.</u>  |  |
| 18. <u>410.9 I</u>   |  | CAUSE OF DEATH   |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH   |  | (A) IMMEDIATE CAUSE <u>Myocardial Infarction</u>   |  |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  |  | DUE TO, OR AS A CONSEQUENCE OF:  |  |
| ANTECEDENT CAUSES  |  | (B) <u>Arteriosclerotic Heart Disease</u>  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  | DUE TO, OR AS A CONSEQUENCE OF:  |  |
| II   |  | (C) _____  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  | <u>Congestive Heart Failure</u>  |  |
| 19A. DATE OF OPERATION   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20A. AUTOPSY? (Yes or No) <u>No</u>  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Oct. 22</u> 19 <u>69</u> to <u>Nov 2</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>Nov. 2</u> 19 <u>69</u> and that (my) (aur) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |
| 23A. SIGNATURE <u>Victor Borden M.D.</u>   |  | 23B. DATE SIGNED <u>Nov-2, 1969</u>  |  |
| 23C. PHYSICIAN'S NAME (Type) <u>VICTOR BORDEN MD</u>   |  | 23D. ADDRESS <u>SINAI HOSPITAL</u>   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   | 24B. DATE <u>11-3-69</u>   | 24C. NAME of CEMETERY or CREMATORY <u>BETH TELLOR</u>  | 24D. LOCATION (City, town, or county) (State) <u>WINDSOR MILL ROAD, MARYLAND</u> |
| 25A. DATE REC'D BY HEALTH DEPT. <u>NOV 5 1969</u>  |  | 25B. NAME OF REGISTRAR <u>John E. Taylor, Jr.</u>  |  |
| 25C. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS.</u>  |  | ADDRESS <u>6010 REISTERSTOWN ROAD</u>  |  |



B-653

69 10867 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 10867

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

RUDOLF BRANDT

2. DATE  
OF  
DEATHKnown ☐  
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

ST. AGNES HOSPITAL (DOA)

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

November 1, 1969

10:08 P.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY Howard

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

C. CITY OR TOWN

Savage

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

Nov. 16, 1901

10. AGE (In years  
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

3205 Offut Road

Randallstown, Md.

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Carpenter

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Unknown

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

106-22-5471

18. INFORMANT

ADDRESS

Mr. Walter H. Kulesa

Sykesville, Md.

19.

E 814.17

CAUSE OF DEATH

Multiple Traumatic Injuries

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

Street

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Rt. 1 and 32, 350 ft. South of intersection 6300

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.) 11-1-69 9:30 P. m.

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Pedestrian struck by hit-and-run driver

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/2/69

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

Nov. 5, 69

24C. NAME OF CEMETERY or CREMATORY

Evergreen Memorial

24D. LOCATION (City, town, or county)

Finksburg, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 5 1969

25B. NAME OF REGISTRAR

Darius E. Gentry, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

J. F. Eline &amp; Sons Reisterstown, Md.

11/6/69 3204 Offutt Rd. Randallstown, Md  
Phone directory CT



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 10868

BIRTH NO.

|   |  |  |  |
|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>ALIEN</b><br><b>Robert Cochran</b>  |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> M.  |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>City Hospital (DOA)</b>   |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>11 2 69 11:30 P.M.</b>  |  |
| 6. SEX<br><b>Male</b>   |  | 7. RACE<br><b>White</b>  |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | C. CITY OR TOWN ( <i>Dundalk</i> )<br><b>Baltimore</b>   |  |
| 9. DATE OF BIRTH<br><b>Oct. 22, 1947</b>  |  | 10. AGE (In years lost birthday)<br><b>22</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>(Harford Co.) Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Cutter (Slip Cover)</b>   |  | 14B. KIND OF BUSINESS OR INDUSTRY<br><b>Slip Cover Mfg.</b>  |  |
| 15. MOTHER'S MAIDEN NAME<br><b>Virginia Ellen Hicks</b>   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>yes</b>  |  |
| 17. SOCIAL SECURITY NO.   |  | 18. INFORMANT (Father) <b>452-5223</b> ADDRESS<br><b>Mr. Wallace R. Cochran Taylor Road</b><br><b>Street, Maryland 21154</b>   |  |
| 19. <b>E 8 15.0</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Cerebro-spinal injuries</b>   |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:                   |  |
| 20A. DATE OF OPERATION  |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>street</b>  |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br><b>Stemmers Run Rd. - 800' N. of Eastern Blvd</b>   |  | 22D. TIME OF INJURY (Approx.)<br><b>11 2 69 11:30 P</b>  |  |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | 22F. HOW DID INJURY OCCUR?<br><b>Subject was driver in car that struck a tree.</b>   |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br><b>Russell S. Fisher, M.D.</b>  |  | DATE SIGNED<br><b>11-3-69</b>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 24B. DATE<br><b>Nov. 5, 1969</b>   |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Bel Air Memorial Gardens</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>Bel Air, Harford Co., Maryland 21014</b>   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 5 1969</b>  |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher, M.D.</b>  |  |
| 25C. FUNERAL DIRECTOR<br><b>Joseph William Foster</b>   |  | ADDRESS<br><b>W. Broadway &amp; Williams St. Bel Air, Maryland 21014</b>   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                     |   |                                    | REG. NO. 69 10869   |   |
|---|---------------------|---|------------------------------------|---|---|
| 1-525   |                     | 69 10869  |                                    | CERTIFICATE OF DEATH  |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>DUNIGAN, MYRILE</b>   |                     | 2. DATE AND HOUR OF DEATH<br><b>10/31/69 7:10 A.M.</b>  |                                    |   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>43 SOUTH BALTIMORE GENERAL HOSPITAL</b>   |                     | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>South St.</b><br>C. CITY OR TOWN <b>Baltimore Md.</b> D. INSIDE CITY LIMITS? <b>2505</b> YES <input type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>3829 South St.</b> |                                    |   |   |
| 5. SEX<br><b>F</b>  | 6. RACE<br><b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>6/29/18</b> | 9. AGE (In years last birthday) <b>51</b>   | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>   |                     | 10B. KIND OF BUSINESS OR INDUSTRY   |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>NEBRASKA</b>                                      |   |
| 13. FATHER'S NAME<br><b>RUDOLPH JAINET</b>  |                     | 14. MOTHER'S MAIDEN NAME<br><b>GRACE KRACKEL</b>  |                                    |   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                     | 16. SOCIAL SECURITY NO.<br><b>216-24-2393</b>   |                                    | 17. INFORMANT <b>Edward Dunigan</b> ADDRESS <b>3829 TENA ST. BALTIMORE 25 MD.</b>                 |   |
| 18. <b>157.9 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)<br><b>Antestine paindise</b><br><b>Carcinoma of pancreas.</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.<br><b>(A) IMMEDIATE CAUSE</b><br><b>DUE TO, OR AS A CONSEQUENCE OF:</b><br><b>(B) Carcinoma of pancreas.</b><br><b>DUE TO, OR AS A CONSEQUENCE OF:</b><br><b>(C)</b> |                     | CAUSE OF DEATH  |                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                     |   |                                    |   |   |
| 19A. DATE OF OPERATION<br><b>10-13-69</b>   |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Esophagus - bypass.</b>  |                                    | 20A. AUTOPSY? (Yes or No)   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                          |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                                    | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                     |   |                                    |   |   |
| 23A. SIGNATURE<br><b>Richard H Reed MD</b><br>DEGREE  |                     |   |                                    | 23B. DATE SIGNED  |   |
| 23C. PHYSICIAN'S NAME (Type)  |                     | 23D. ADDRESS  |                                    |   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                     | 24B. DATE<br><b>11-3-69</b>   |                                    | 24C. NAME of CEMETERY or CREMATORY<br><b>ST ALPHONSUS</b>   |   |
| 24D. LOCATION<br><b>WOODSTOCK, MD</b>   |                     | 24E. LOCATION (City, town, or county) (State)   |                                    |   |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 5 1969</b>  |                     | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor</b>   |                                    | 25C. FUNERAL DIRECTOR<br><b>Higginbotham, Slack</b> ADDRESS <b>ELLICOTT ST. BALTIMORE 2121043</b> |   |

Antonia Smith

Antonia J. Smith

10-17-1914

Antonia J. Smith

69 10870

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

REG. NO.

69 10870

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
| N-240  |  | 69 10870   |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | X  |  | REG. NO. 69 10870  |  |
| BIRTH NO.  |  | 1. NAME OF DECEASED (Type or Print)  |  | JOSEPH NICKOL  |  | 2. DATE AND HOUR OF DEATH  |  | 10/30/69 10 45 a.m.  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)  |  | A. STATE MARYLAND  |  | B. COUNTY BALTO. CO.   |  | 5300   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION   |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |  | BALTIMORE CITY HOSPITALS   |  | C. CITY OR TOWN BALTIMORE  |  | D. INSIDE CITY LIMITS? YES [X] NO [ ]                          |  |
| 31   |  | 4940 EASTERN AVENUE  |  | BALTIMORE, MARYLAND 21224  |  | E. STREET AND NUMBER   |  | 6844 FAIT AVENUE 21229 007                                     |  |
| 5. SEX MALE  |  | 6. RACE WHITE  |  | 7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X]                |  | 8. DATE OF BIRTH 12-30-13  |  | 9. AGE (In years last birthday) 56                             |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)              |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)                                |  | 12. CITIZEN OF WHAT COUNTRY?   |  | MD US 17   |  |
| 13. FATHER'S NAME  |  | 14. MOTHER'S MAIDEN NAME   |  | MICHAEL  |  | ANNA   |  | P  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  | ADDRESS  |  | VWK 216-07-3113 BCH RECORDS-4940 EASTERN AVE. BALTO. MD. 21224 |  |
| 18. CAUSE OF DEATH   |  | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH   |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                      |  | 24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |  | 37191 sepsis 24 hrs.   |  |
| ANTECEDENT CAUSES  |  | DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                        |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                      |  |  |  | 48 hrs.  |  |
|  |  |  |  | (C) acute hepatic failure 2° cirrhosis                                   |  |  |  | years  |  |
| II   |  | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |  |  |  |  |  |  |  |
| 19A. DATE OF OPERATION   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  | YES YES  |  |
| 21A. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (notify medical examiner)            |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |  |  |  |  |
| 21D. TIME OF INJURY (APPROX.)  |  | 21E. INJURY OCCURRED   |  | 21F. HOW DID INJURY OCCUR?   |  |  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from  |  | 10/24  |  | 19 69 to 10/30   |  | 19 69  |  |  |  |
| that (I) (we) last saw the deceased alive on   |  | 10/30  |  | 19 69  |  | and that in (my) (our) opinion death occurred on the date            |  |  |  |
| and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.           |  |  |  |  |  |  |  |  |  |
| 23A. SIGNATURE   |  | 23B. DATE SIGNED   |  | John R. Neeffe MD  |  | 10/30/69   |  |  |  |
| 23C. PHYSICIAN'S NAME (Type)   |  | 23D. ADDRESS   |  | JOHN R. NEEFFE, MD.  |  | BALTIMORE CITY HOSPITALS   |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |  | 24B. DATE  |  | 24C. NAME OF CEMETERY or CREMATORY                                       |  | 24D. LOCATION (City, town, or county)                                |  | (State)  |  |
| BURIAL   |  | 11/3/69  |  | SACRED HEART OF JESUS  |  | BALTO. MD.   |  |  |  |
| 25A. DATE DECEASED BY HEALTH DEPT.   |  | 25B. NAME OF REGISTRAR   |  | 25C. FUNERAL DIRECTOR  |  | ADDRESS  |  |  |  |
| OCT 5 1969   |  | John R. Neeffe, MD   |  | J. G. CONNELLY   |  | 300 MACE   |  |  |  |

1. 10/13/73

2. 10/13/73

3. 10/13/73

4. 10/13/73

5. 10/13/73

6. 10/13/73

7. 10/13/73

## CERTIFICATE OF DEATH

69 10871

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Hart, Carroll

2. DATE AND HOUR OF DEATH

2:45 pm 10/30/69

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)Baltimore City Hospitals  
4940 Eastern Ave.  
Baltimore, Md. 21224

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Maryland Baltimore

C. CITY OR TOWN

ESSEX

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

425 Lorraine Ave. 21221 005

5. SEX

Male

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

9-18-04

9. AGE (In years  
lost birthday)

65

If Under 1 Yr.  
Months DaysIf Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Wesley HART

14. MOTHER'S MAIDEN NAME

Ida Givens

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

UNK

16. SOCIAL  
SECURITY NO.

218-63-2431

17. INFORMANT

4940 Eastern Ave.

ADDRESS

BCH Records: Baltimore, Md. 21224

18. 427.0 I

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

Cardiac Arrest

(B) DUE TO, OR AS A CONSEQUENCE OF:

Congestive Heart Disease

(C) DUE TO, OR AS A CONSEQUENCE OF:

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10-30 69 to 10-30 69  
that (I) (we) last saw the deceased alive on 10-30 69 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Jack D. Mc Cue

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

10/30/69

23C. PHYSICIAN'S  
NAME (Type)

Jack D. Mc Cue MD.

DEGREE

23D. ADDRESS

Baltimore City Hospitals

DEGREE

4940 Eastern Ave. Baltimore, Md. 21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

11/3/69

24C. NAME OF CEMETERY or CREMATORY

HOLLY HILL

24D. LOCATION

(City, town, or county)

(State)

BALTO. MD.

25A. DATE REC'D BY HEALTH DEPT.

NOV 5 1969

25B. NAME OF REGISTRAR

Robert E. Taylor, MD

25C. FUNERAL DIRECTOR

J. E. CONNELLY SEAS 300 N. ALCE

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



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1

L-600

69 10872 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 10872

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARY B. LOWERY

2. DATE OF DEATH Known ☒ Estimated ☐ Month Day Year Hour M. October 29, 1969

3. DATE OF PRONOUNCED DEAD Month Day Year Hour M. October 29, 1969 7:30 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital (DO)A

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 906

6. SEX Female 7. RACE White B. MARRIED ☐ NEVER MARRIED ☐ C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES ☒ NO ☐

8. WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH 9/21/88 10. AGE (In years last birthday) 81 11. BIRTHPLACE (State or foreign country) MD. 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME NICHOLAS GEHRING

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HW. 14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME MARY HART LOVE

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO 17. SOCIAL SECURITY NO. 213-65-7658 18. INFORMANT ADDRESS SHERMAN HUDSON 4240 SHELTON

19. CAUSE OF DEATH Arteriosclerotic cardiovascular disease

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) No

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 22F. HOW DID INJURY OCCUR?

23. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Charles S. Springate M.D. CHIEF MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED October 30, 1969

24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL 24B. DATE 11/3/69 24C. NAME OF CEMETERY or CREMATORY HOLY REDEEMER 24D. LOCATION (City, town, or county) (State) BALTO. MD.

25A. DATE REC'D BY HEALTH DEPT. NOV 5 1969 25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR ADDRESS J.G. CONNELLY SONS 300 MACE

88 10/27

88 10/27

WILLIAM J. BROWN  
MARTIN LUTHER KING, JR.

WILLIAM J. BROWN  
MARTIN LUTHER KING, JR.

WILLIAM J. BROWN  
MARTIN LUTHER KING, JR.

WILLIAM J. BROWN  
MARTIN LUTHER KING, JR.

WILLIAM J. BROWN  
MARTIN LUTHER KING, JR.

WILLIAM J. BROWN  
MARTIN LUTHER KING, JR.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                  |  |                              |   |   |
|--|------------------|--|------------------------------|---|---|
| P-100 69 10873   |                  | BALTIMORE CITY HEALTH DEPARTMENT   |                              | X REG. NO. 69 10873   |   |
| BIRTH NO.  |                  | 1. NAME OF DECEASED<br>(Type or Print)   |                              | 2. DATE AND HOUR OF DEATH   |   |
|  |                  | POPE, LOUISE, MARGARET   |                              | NOVEMBER 2, 1969 10:30 P.M.   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  |                              |   |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>40 ST AGNES HOSPITAL<br>WILKENS & CATON AVES<br>BALTIMORE MARYLAND 21229   |                  | A. STATE<br>MARYLAND<br>B. COUNTY<br>Howard Co. 6300   |                              | C. CITY OR TOWN<br>HANOVER  |   |
|  |                  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                              | E. STREET AND NUMBER<br>FOREST AVE BOX 258 RT #2  |   |
| 5. SEX<br>FEMALE   | 6. RACE<br>WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>      | 8. DATE OF BIRTH<br>04 08 87 | 9. AGE (In years last birthday)<br>82   | 10. If Under 1 Yr. Months Days<br>If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>HOUSEWIFE   |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>Own Home  |                              | 11. BIRTHPLACE (State or foreign country)<br>MARYLAND   |   |
| 13. FATHER'S NAME<br>UNKNOWN   |                  | 14. MOTHER'S MAIDEN NAME<br>MARGARET ( ? )   |                              | 12. CITIZEN OF WHAT COUNTRY?<br>U S A   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>no   |                  | 16. SOCIAL SECURITY NO.<br>NONE  |                              | 17. INFORMANT ADDRESS<br>WILKENS & CATON AVES BALTO MD 21229<br>ST AGNES HOSPITAL RECORDS   |   |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>Pulmonary infection<br>Gastric Intestinal bleeding<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____ |                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                  |  |                              |   |   |
| 19A. DATE OF OPERATION<br>2  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                              | 20A. AUTOPSY? (Yes or No)<br>YES  |   |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                              | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX.)   |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                              | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (X) (this hospital) attended the deceased from OCTOBER 17 19 69 to NOVEMBER 2 19 69 that (X) (we) last saw the deceased alive on NOVEMBER 2 19 69 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.                               |                  |  |                              |   |   |
| 23A. SIGNATURE<br>Sabanoyagam  |                  | 23B. DATE SIGNED<br>Nov 3 1969   |                              | 23C. PHYSICIAN'S NAME (Type)<br>SABANOYAGAM, P. MD.   |   |
| 23D. ADDRESS<br>ST. AGNES HOSP. BALTO.MD. 21228  |                  | 23E. PHYSICIAN'S DEGREE<br>MD.   |                              | 23F. PHYSICIAN'S SPECIALTY<br>Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial   |                  | 24B. DATE<br>11/6/69   |                              | 24C. NAME of CEMETERY or CREMATORY<br>Meadowridge Memorial Pk.  |   |
| 24D. LOCATION<br>Elkridge, Maryland  |                  | 24E. NAME of REGISTRAR<br>Robert E. Taylor   |                              | 24F. FUNERAL DIRECTOR<br>Singleton Funeral Home   |   |
| 24G. DATE REC'D BY HEALTH DEPT.<br>NOV 5 1969  |                  | 24H. NAME of REGISTRAR<br>Robert E. Taylor   |                              | 24I. ADDRESS<br>7 Glen Burnie, Md.  |   |

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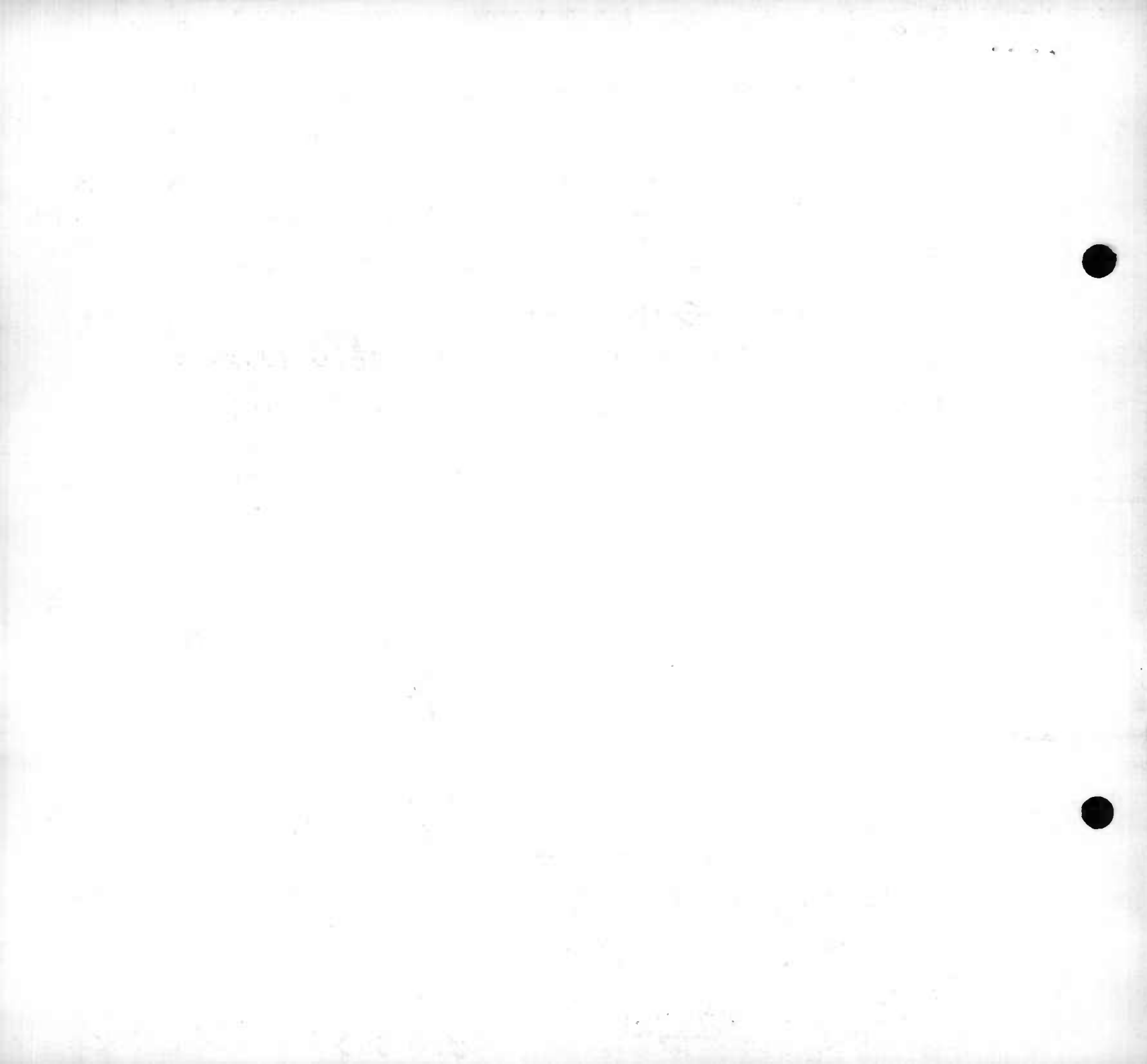
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                  |   |   |  |   |   |   |                       |  |
|--|------------------|---|---|--|---|---|---|-----------------------|--|
| F-652  |                  | 69 10874  |   | BALTIMORE CITY HEALTH DEPARTMENT                                       |   | X   |   | REG. NO. 69 10874     |  |
| BIRTH NO.  |                  |   |   |  | 2. DATE AND HOUR OF DEATH   |   |   |                       |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>THELMA MARIE FRANKLIN</b>  |                  |   |   |  | Nov. 3, 1969 10:06 A.M.   |   |   |                       |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                  |   |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)   |   |   |                       |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>UNIVERSITY OF MARYLAND HOSPITAL</b>   |                  |   |   |  | A. STATE <b>MD.</b> 8. COUNTY <b>ANNE ARUNDEL</b> 5200  |   |   |                       |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |                  |   |   |  | C. CITY OR TOWN <b>SEVERN</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> |   |   |                       |  |
| E. STREET AND NUMBER<br><b>338 QUATERFIELD RD 21144</b>  |                  |   |   |  |   |   |   |                       |  |
| 5. SEX <b>F</b>  | 6. RACE <b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH <b>3-23-13</b>  | 9. AGE (in years last birthday) <b>56</b>   | If Under 1 Yr. Months Days  |   | If Under 24 Hrs. Min. |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>  |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>MD.</b>                |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                |   |                       |  |
| 13. FATHER'S NAME<br><b>AUGUST BRANDNER</b>  |                  |   |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Rosalia Wyford</b>   |   |   |                       |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>  |                  |   | 16. SOCIAL SECURITY NO.<br><b>UNKNOWN</b> |  | 17. INFORMANT<br><b>HOSP. CHART</b>   |   | ADDRESS   |                       |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>HEPATOSPLENO MEGALY &amp; MARKED ASCITES - Etio?</b>   |                  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 yrs</b>  |   |   |                       |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II RHEUMATIC HEART DISEASE</b>  |                  |   |   |  |   |   |   |                       |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                  |   |   |  |   |   |   |                       |  |
| 19A. DATE OF OPERATION<br><b>2</b>   |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)<br><b>YES</b>                                |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?      |   |                       |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initial medical examiner)   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21C. WHERE DID INJURY OCCUR?   |   | (If in Baltimore City, give exact location)                               |   |                       |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |   | 21F. HOW DID INJURY OCCUR?   |   |   |   |                       |  |
| 22. I certify that (H) (this hospital) attended the deceased from <b>NOV 1 1969</b> to <b>NOV 3 1969</b> that (I) (we) last saw the deceased alive on <b>NOV 3 1969</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                  |   |   |  |   |   |   |                       |  |
| 23A. SIGNATURE<br><b>Marvin J. Gordon, M.D.</b>  |                  |   |   |  | 23B. DATE SIGNED<br><b>Nov 3, 1969</b>  |   | 23C. PHYSICIAN'S NAME (Type)<br><b>MARVIN J. GORDON, M.D.</b> |                       |  |
| 23D. ADDRESS<br><b>DEPT. OF MEDICINE, UNIV OF MD. HOSP</b>   |                  |   |   |  |   |   |   |                       |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                  | 24B. DATE<br><b>11/7/1969</b>   |   | 24C. NAME OF CEMETERY or CREMATORY<br><b>Glenn Haven Memorial Park</b> |   | 24D. LOCATION (City, town, or county) (State)<br><b>Glenn Burnie, Md.</b> |   |                       |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 5 1969</b>   |                  | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>   |   | 25C. FUNERAL DIRECTOR<br><b>Robert E. Taylor, M.D.</b>                 |   | ADDRESS<br><b>Glenn Burnie, Md.</b>                                       |   |                       |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| <div style="display: flex; justify-content: space-between;"> <span><b>G-615</b></span> <span><b>BALTIMORE CITY HEALTH DEPARTMENT</b></span> </div> <div style="display: flex; justify-content: space-between;"> <span><b>69 10875</b></span> <span><b>CERTIFICATE OF DEATH</b></span> <span>REG. NO. <b>69 10875</b></span> </div> |  |  |  |  |  |
| BIRTH NO.  |  | 1. NAME OF DECEASED<br>(Type or Print) <b>Griffin, Pauline</b>   |  | 2. DATE AND HOUR OF DEATH<br><b>6th Nov. 1, 69 1:20 A.M.</b>   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>BALTO.</b>                     |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>North Charles General Hospital</b>  |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>19424 N. Charles St.</b>            |  | C. CITY OR TOWN <b>BALTO. ESSEX</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                           |  |
| 5. SEX <b>F</b>  |  | 6. RACE <b>W</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH <b>9/3/15</b>   |  | 9. AGE in years (lost birthday) <b>54</b>  |  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  | 10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>   |  | 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>   |  | 13. FATHER'S NAME <b>John Smith</b>  |  | 14. MOTHER'S MAIDEN NAME <b>Dora Love</b>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NAK</b>   |  | 16. SOCIAL SECURITY NO. <b>213 204048</b>  |  | 17. INFORMANT <b>Hosp. chart</b> ADDRESS   |  |
| 18. <b>562.01</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Generalized Peritonitis</b>  |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>ruptured diverticulum of ileum</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.   |  | (B) DUE TO, OR AS A CONSEQUENCE OF:  |  | (C) DUE TO, OR AS A CONSEQUENCE OF:  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |  |  |  |  |  |
| 19A. DATE OF OPERATION <b>2</b>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY (Yes or No) <input checked="" type="checkbox"/>   |  |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |  |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                       |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>         |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (this hospital) attended the deceased from <b>10/25 1969</b> to <b>11/1 1969</b> , that (I) last saw the deceased alive on <b>11/1 1969</b> and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.                       |  |  |  |  |  |
| 23A. SIGNATURE <b>John D. G. [Signature]</b>   |  |  |  | 23B. DATE SIGNED   |  |
| 23C. PHYSICIAN'S NAME (Type)   |  | DEGREE   |  | 23D. ADDRESS   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |  | 24B. DATE <b>11/4/69</b>   |  | 24C. NAME OF CEMETERY or CREMATORY <b>MORELANDS</b>  |  |
| 24D. LOCATION (City, town, or county) <b>BALTO. MD.</b>  |  | 24E. (State)   |  |  |  |
| NOV 5 1969   |  | NAME OF REGISTRAR <b>J. E. [Signature]</b>   |  | 25C. FUNERAL DIRECTOR <b>J. E. [Signature]</b> ADDRESS <b>300 more</b>   |  |

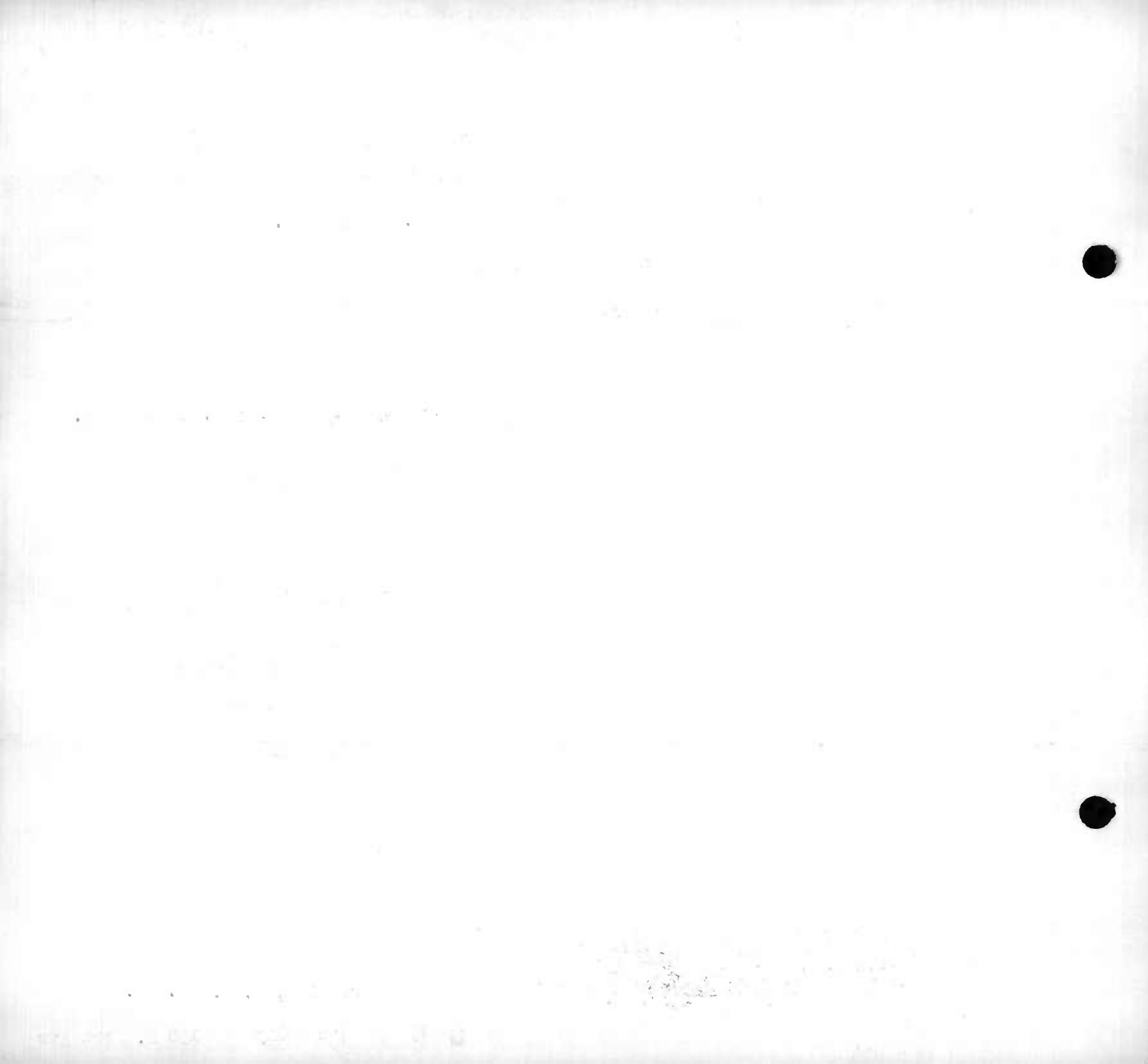




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                      |   |                                   | 69 10876   |  |
|---|----------------------|---|-----------------------------------|--|--|
| BIRTH NO. <span style="float: right;">69 10876</span>   |                      | 1. NAME OF DECEASED<br>(Type or Print) <b>KELLAM, ELLEN NORA</b>  |                                   | 2. DATE AND HOUR OF DEATH<br><b>11-3-1969 11:15 AM</b>                                     |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                      | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)   |                                   |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>FRANKLIN Squ. Hospital</b>   |                      | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |                                   | A. STATE <b>MD</b><br>B. COUNTY <b>BALTO</b>   |  |
|   |                      | C. CITY OR TOWN <b>BALTO</b>  |                                   | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
|   |                      | E. STREET AND NUMBER <b>1225 S. Hanover St.</b>   |                                   |  |  |
| 5. SEX<br><b>Female</b>   | 6. RACE<br><b>W.</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>8-7-85</b> | 9. AGE (In years last birthday)<br><b>84</b>   | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>  |                      | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>   |                                   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                               |  |
| 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A</b>   |                      | 13. FATHER'S NAME<br><b>John Lushy</b>  |                                   | 14. MOTHER'S MAIDEN NAME<br><b>Annie Coster</b>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                      | 16. SOCIAL SECURITY NO.<br><b>214, 44 2982-11</b>   |                                   | 17. INFORMANT <b>Wesley Lushy</b> ADDRESS <b>1225 S. Hanover St.</b>                       |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>Probable heart failure</b>  |                      | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>old age, malnutrition, anemia</b>   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b>   |                      |   |                                   |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |                      |   |                                   |  |  |
| 19A. DATE OF OPERATION  |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                   | 20A. AUTOPSY? (Yes or No) <b>No</b>  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                      | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                                   | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10, 21, 69</b> 19 <b>62</b> to <b>11-3-69</b> 19 <b>69</b> that (I) (we) last saw the deceased alive on <b>11-3-69</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                      |   |                                   |  |  |
| 23A. SIGNATURE<br><b>ASSAD Ryzk</b>   |                      |   |                                   | 23B. DATE SIGNED<br><b>11-3-1969</b>   |  |
| 23C. PHYSICIAN'S NAME (Type)  |                      | 23D. ADDRESS  |                                   |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                      | 24B. DATE<br><b>11 6 69</b>   |                                   | 24C. NAME of CEMETERY or CREMATORY<br><b>Cedar Hill</b>                                    |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Brenklyn, A. A. Co. Md.</b>   |                      |   |                                   |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 5 1969</b>  |                      | 25B. NAME OF REGISTRAR<br><b>James E. James, M.D.</b>   |                                   | 25C. FUNERAL DIRECTOR<br><b>Mc Gully</b> ADDRESS <b>130 E. Fort Ave</b>                    |  |



1

G-430 69 10877 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 10877

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CLARA GOULD

2. DATE OF DEATH Known ☐ Month Day Year Hour M. Estimated ☐ M.

3. DATE OF DEATH Pronounced Dead Month Day Year Hour November 1, 1969 9:15 A. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD SINAI HOSPITAL (DOA)

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE D.C. B. COUNTY V-48

6. SEX Female 7. RACE White 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ 9. DATE OF BIRTH Sept 17-1891 10. AGE (In years lost birthday) 78 65 11. BIRTHPLACE (State or foreign country) Mass. 12. CITIZEN OF WHAT COUNTRY? USA 13. FATHER'S NAME Martin A. Gould 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retd 14B. KIND OF BUSINESS OR INDUSTRY US Govt. 15. MOTHER'S MAIDEN NAME Adaline Eton 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (if yes, give war or dates of service) no 17. SOCIAL SECURITY NO. 579605854 18. INFORMANT Grace Gould King 19. CAUSE OF DEATH Drowning 20. DATE OF OPERATION 21. AUTOPSY? (Yes or No) yes 22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Bathtub 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 4000 Forest Hill Road 2841 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 11-1-69 A.M. 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 22F. HOW DID INJURY OCCUR? Subject drowned in bathtub 23. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ ACTUAL SIGNATURE [Signature] M.D. CHIEF MEDICAL EXAMINER DATE SIGNED 11/2/69 EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐ 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE Nov. 4-69 24C. NAME OF CEMETERY or CREMATORY Mt. Olivet Cemetery 24D. LOCATION (City, town, or county) (State) Washington DC 25A. DATE REC'D BY HEALTH DEPT. NOV 5 1969 25B. NAME OF REGISTRAR Robert E. Taylor 25C. FUNERAL DIRECTOR ADDRESS Wash DC Simmons Bros 1661-Good Hope Rd SE

Letter dated 12/5/69 from Dr. Ronald N. Kornblum

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

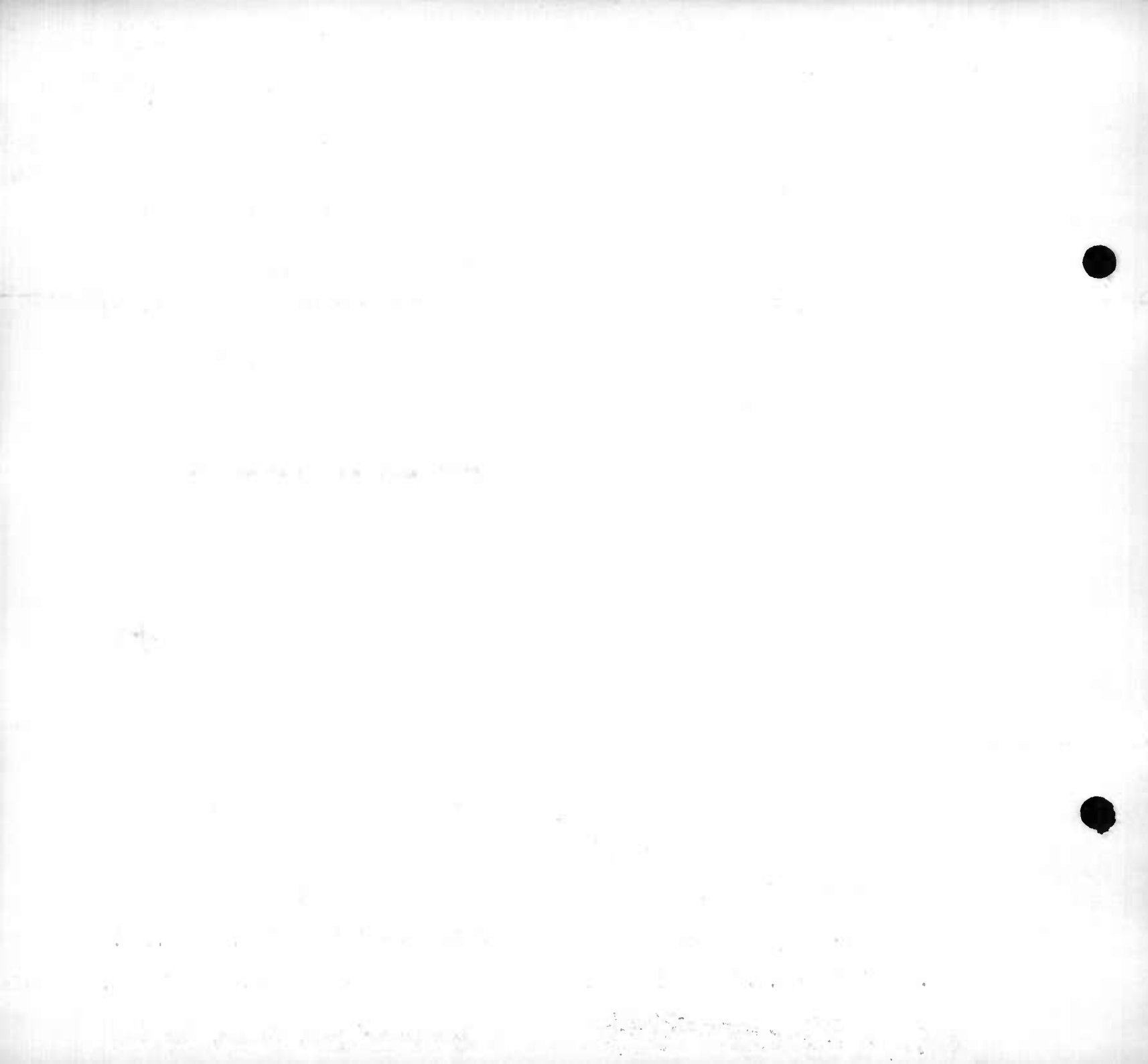
| BALTIMORE CITY HEALTH DEPARTMENT   |  |   |   | REG. NO. <b>69 10878</b>  |
|--|--|---|---|---|
| <b>B-320</b><br><b>BIRTH NO.</b><br><b>69 10878</b>  |  | <b>CERTIFICATE OF DEATH</b>   |   |   |
| <b>1. NAME OF DECEASED</b><br>(Type or Print) <b>John Wilmer Bates</b>   |  | <b>2. DATE AND HOUR OF DEATH</b><br><b>November 2, 1969 11:45 A. M.</b>   |   |   |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><br><b>4. USUAL RESIDENCE</b> (Where deceased lived, If institution: residence before admission)<br>A. STATE <b>MD.</b><br>B. COUNTY <b>909</b>   |  | <b>5. CITY OR TOWN</b><br><b>BALTIMORE</b><br><b>6. INSIDE CITY LIMITS?</b><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |   |
| <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location)<br><b>The Gould Convalesarium</b><br><b>90 - 6116 BELAIR ROAD</b><br><b>BALTIMORE - MARYLAND</b>  |  | <b>7. STREET AND NUMBER</b><br><b>1525 HOLBROOK ST.</b>   |   |   |
| <b>5. SEX</b><br><b>Male</b>   | <b>6. RACE</b><br><b>White</b>   | <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>                                       | <b>8. DATE OF BIRTH</b><br><b>2 JAN 1897</b>                                | <b>9. AGE</b> (In years last birthday)<br><b>72</b>                   |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>ENGINEER</b>  |  | <b>10B. KIND OF BUSINESS OR INDUSTRY</b><br><b>RAILROAD</b>   |   | <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>MD.</b>        |
| <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>U. S. A.</b>   |  | <b>13. FATHER'S NAME</b><br><b>JOHN H. BATES</b>  |   |   |
| <b>14. MOTHER'S MAIDEN NAME</b><br><b>ISABELLE MCCARTHY</b>  |  | <b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>  |   |   |
| <b>16. SOCIAL SECURITY NO.</b><br><b>717-07-8660</b>   |  | <b>17. INFORMANT</b><br><b>Mrs. John Keller, 4666 KERNWOOD AVE.</b>   |   |   |
| <b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>25019 I</b>  |  | <b>CAUSE OF DEATH</b><br><b>(A) IMMEDIATE CAUSE</b> <b>Pulmonary Embolism</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>(B) Cardio Vascular Arteriosclerotic Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Diabetes</b> |   |   |
| <b>19. ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  | <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b><br><b>2 hours.</b><br><b>1 year.</b><br><b>?</b>  |   |   |
| <b>II</b>  |  |   |   |   |
| <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>  |  |   |   |   |
| <b>19A. DATE OF OPERATION</b><br><b>2</b>  | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>  | <b>20A. AUTOPSY?</b> (Yes or No)  | <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> |   |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner)   | <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg, etc.)                   | <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)   |   |   |
| <b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)   | <b>21E. INJURY OCCURRED</b><br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | <b>21F. HOW DID INJURY OCCUR?</b>   |   |   |
| <b>22. I certify that (I) (the hospital) attended the deceased from November 1, 1969 to November 2, 1969, that (I) (we) last saw the deceased alive on November 1, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</b> |  |   |   |   |
| <b>23A. SIGNATURE</b><br><b>Michael J. Dausch, M.D.</b>  |  | <b>23B. DATE SIGNED</b><br><b>11/2/69</b>   |   | <b>23C. PHYSICIAN'S NAME</b> (Type)<br><b>Michael J. DAUSCH, M.D.</b> |
| <b>24A. BURIAL, CREMATION, REMOVAL (Specify)</b><br><b>BURIAL</b>  |  | <b>24B. DATE</b><br><b>11-5-69</b>  |   |   |
| <b>24C. NAME OF CEMETERY or CREMATORY</b><br><b>DRUID RIDGE CEMETERY</b>   |  | <b>24D. LOCATION</b> (City, town, or county) (State)<br><b>BALTO. CO., MD.</b>  |   |   |
| <b>25A. DATE REC'D BY HEALTH DEPT.</b><br><b>NOV 5 1969</b>  |  | <b>25B. NAME OF REGISTRAR</b><br><b>Clifford F. ...</b>   |   |   |
| <b>25C. FUNERAL DIRECTOR</b><br><b>Clifford F. ...</b>   |  | <b>ADDRESS</b><br><b>11206 ...</b>  |   |   |

THE STATE OF NEW YORK  
IN SENATE  
January 1, 1901.  
REPORT  
OF THE  
COMMISSIONERS OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 1, 1899.  
ALBANY:  
J. B. LIPPINCOTT & CO. PRINTERS.  
1901.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                  |   |  |
|--|------------------|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT   |                  | REG. NO. <b>69 10879</b>  |  |
| BIRTH NO. <b>N-450</b>   |                  | 69 10879  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>JEAN S. NEWLON</b>   |                  | 2. DATE AND HOUR OF DEATH<br><b>10/30/69 12<sup>30</sup> A.M.</b>   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>44 UNION MEMORIAL HOSP.</b>  |                  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>21234 5300</b><br>C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>2908 KING RIDGE ROAD</b> |  |
| 5. SEX <b>F</b>  | 6. RACE <b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <b>4/2/10</b> 9. AGE (In years last birthday) <b>59</b><br>if Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>  |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Our Home</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>ILLINOIS</b>   |                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>CLYDE SCHWARTZ</b>   |                  | 14. MOTHER'S MAIDEN NAME<br><b>ETHYL O NEILL</b>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No None</b>   |                  | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><b>ADMISSION HISTORY - UNION MEM HOSP.</b>  |                  | ADDRESS   |  |
| 18. <b>410-9 I</b> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br>19A. DATE OF OPERATION <b>2</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>20A. AUTOPSY? (Yes or No) <b>YES</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)<br>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx)<br>21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/><br>21F. HOW DID INJURY OCCUR?<br>22. I certify that (1) (this hospital) attended the deceased from <b>10/27</b> 19 <b>69</b> to <b>10/30</b> 19 <b>69</b> that (1) (we) last saw the deceased alive on <b>10/30</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.<br>23A. SIGNATURE <b>Anne L. Leddy M.D.</b> 23B. DATE SIGNED<br>23C. PHYSICIAN'S NAME (Type) <b>Anne L. Leddy</b> 23D. ADDRESS <b>Union Memorial Hospital, Balto., Md.</b><br>24A. BURIAL CREMATION, REMOVAL (Specify) <b>Rem./Burial</b> 24B. DATE <b>Nov. 3, 1969</b> 24C. NAME OF CEMETERY OR CREMATORY <b>Riverside Cemetery</b> 24D. LOCATION (City, town, or county) (State) <b>Prophetstown, Whiteside Co., Illinois</b><br>25A. DATE REC'D BY HEALTH DEPT. <b>NOV 5 1969</b> 25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b> 25C. FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Maryland</b> ADDRESS |                  |   |  |





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |   |  |
|---|--|---|--|
| <p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>   |  | <p>REG. NO. <b>69 10880</b></p>   |  |
| <p><b>BIRTH NO.</b> <b>P-320</b></p>  |  | <p><b>DATE AND HOUR OF DEATH</b> <b>1 Nov 69 1152 P</b></p>   |  |
| <p><b>1. NAME OF DECEASED</b> (Type or Print) <b>Clifford Patch</b></p>   |  | <p><b>2. DATE AND HOUR OF DEATH</b> <b>1 Nov 69 1152 P</b></p>  |  |
| <p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p>  |  | <p><b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission)</p>   |  |
| <p><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Mercy Hospital</b></p>   |  | <p><b>A. STATE</b> <b>MARYLAND</b> <b>B. COUNTY</b> <b>Baltimore</b></p>  |  |
| <p><b>5. SEX</b> <b>M</b> <b>6. RACE</b> <b>W</b></p>   |  | <p><b>C. CITY OR TOWN</b> <b>Towson</b> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> |  |
| <p><b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>   |  | <p><b>E. STREET AND NUMBER</b> <b>523 Alleghany Ave</b></p>   |  |
| <p><b>8. DATE OF BIRTH</b> <b>8/11/03</b> <b>9. AGE</b> (In years last birthday) <b>66</b></p>  |  | <p><b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Tree Surgeon-retired</b></p>          |  |
| <p><b>11. BIRTHPLACE</b> (State or foreign country) <b>VERMONT</b></p>  |  | <p><b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b></p>   |  |
| <p><b>13. FATHER'S NAME</b> <b>Lyford Patch</b></p>   |  | <p><b>14. MOTHER'S MAIDEN NAME</b> <b>Lena Geriot</b></p>   |  |
| <p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>WW II</b></p>  |  | <p><b>16. SOCIAL SECURITY NO.</b> <b>020-05-9726A</b></p>   |  |
| <p><b>17. INFORMANT</b> <b>Family records</b></p>   |  | <p><b>ADDRESS</b></p>   |  |
| <p><b>18. CAUSE OF DEATH</b></p>  |  |   |  |
| <p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Subarachnoid Hemorrhage</b></p>   |  |   |  |
| <p><b>ANTECEDENT CAUSES</b> (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.) <b>Intracerebral Aneurysm</b></p>   |  |   |  |
| <p><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b></p>  |  |   |  |
| <p><b>19A. DATE OF OPERATION</b> <b>11 Oct 69</b></p>   |  | <p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>  |  |
| <p><b>20A. AUTOPSY?</b> (Yes or No) <b>No</b></p>   |  | <p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>  |  |
| <p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)</p>   |  | <p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>  |  |
| <p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>  |  | <p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)</p>   |  |
| <p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>  |  | <p><b>21F. HOW DID INJURY OCCUR?</b></p>  |  |
| <p><b>22. I certify that (this hospital) attended the deceased from <b>17 Oct 69</b> to <b>1 Nov 69</b> that (I) (we) last saw the deceased alive on <b>1 Nov 69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p> |  |   |  |
| <p><b>23A. SIGNATURE</b> <b>Edward D. Lannan</b></p>  |  | <p><b>23B. DATE SIGNED</b> <b>2 Nov 69</b></p>  |  |
| <p><b>23C. PHYSICIAN'S NAME (Type)</b> <b>Edward D. Lannan</b></p>  |  | <p><b>23D. ADDRESS</b> <b>Mercy Hospital</b></p>  |  |
| <p><b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Removal/burial</b></p>  |  | <p><b>24B. DATE</b> <b>Nov. 5, 1969</b></p>   |  |
| <p><b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>Oak Grove Cemetery</b></p>  |  | <p><b>24D. LOCATION</b> (City, town, or county) (State) <b>Enfield, New Hampshire</b></p>   |  |
| <p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>NOV 5 1969</b></p>   |  | <p><b>25B. NAME OF REGISTRAR</b> <b>John E. Fisher, M.D.</b></p>  |  |
| <p><b>25C. FUNERAL DIRECTOR</b> <b>John Burns' Sons, Towson, Maryland</b></p>   |  | <p><b>ADDRESS</b></p>   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. <span style="font-size: 2em;">K-100</span> <span style="font-size: 2em;">69 10881</span> <span style="font-size: 2em;">BALTIMORE CITY HEALTH DEPARTMENT</span> <span style="font-size: 2em;">X</span> <span style="font-size: 2em;">REG. NO. 69 10881</span>   |                      |  |  |
|--|----------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>EUGENE L. KIBBE</b>  |                      | 2. DATE AND HOUR OF DEATH<br><b>11-1-69 ; 11:24 AM</b>   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>NORTH CHARLES GENERAL HOSPITAL<br/>49 CHARLES E 28TH ST. BALTIMORE, MD.</b>  |                      | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO. CO.</b><br>C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>304 DIXIE DANE</b> |  |
| 5. SEX <b>MALE</b>   | 6. RACE <b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <b>12-12-11</b>           |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>SALES MANAGER - MORGAN MILLS INC.</b>  |                      | 9. AGE (In years last birthday) <b>57</b>  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> |
| 13. FATHER'S NAME <b>AUGUSTUS KIBBE</b>  |                      | 14. MOTHER'S MAIDEN NAME <b>MAUDE SPEAKMAN</b>   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <b>NO</b>  |                      | 16. SOCIAL SECURITY NO. <b>NONE</b>  |  |
| 17. INFORMANT <b>PATIENT</b>   |                      | ADDRESS  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>410.9 ACUTE MYOCARDIAL Infarction</b><br><b>Complicated by VENTRICULAR FIBRILLATION unknown</b>   |                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                      | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C)  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |                      |  |  |
| 19A. DATE OF OPERATION <b>0</b>  |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20A. AUTOPSY? (Yes or No) <b>NO</b>  |                      | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                      | 21D. TIME OF INJURY (APPROX.)  |  |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                      | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that <del>the</del> (this hospital) attended the deceased from <b>10-24-1969</b> to <b>11-1-1969</b> , that <del>the</del> (we) last saw the deceased alive on <b>11-1-1969</b> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <del>did</del> (did not) view the body after death. |                      |  |  |
| 23A. SIGNATURE <b>Juan Gan</b>   |                      | 23B. DATE SIGNED <b>11-1-69</b>  |  |
| 23C. PHYSICIAN'S NAME (Type) <b>JUAN GAN</b>   |                      | 23D. ADDRESS <b>North Charles Gen Hosp.</b>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>   |                      | 24B. DATE <b>11/4/69</b>   |  |
| 24C. NAME OF CEMETERY or CREMATORY <b>Dulaney Valley Mem. Gdns.</b>  |                      | 24D. LOCATION (City, town, or county) (State) <b>Cockersville, Md.</b>   |  |
| 25A. DATE REC'D BY HEALTH DEPT. <b>NOV 5 1969</b>  |                      | 25B. NAME OF REGISTRAR <b>Robert E. Taylor, Md.</b>  |  |
| 25C. FUNERAL DIRECTOR <b>John B. Bowers' Sons, Towson, Md.</b>   |                      | ADDRESS  |  |

Committee of the Board of Directors  
of the University of California

Z-452

69 10882 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 10882

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Phillip Zellinger

2. DATE  
OF  
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

31

City Hospital

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

2605

6. SEX

Male

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore 21224

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

JAN. 11, 1888

10. AGE (In years  
last birthday)

81

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

716 Rappola St.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ZELLINGER

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

ASSEMBLY LINE

14B. KIND OF BUSINESS OR INDUSTRY

AUTO MFG. R.

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

(?)

17. SOCIAL  
SECURITY NO.

212-01-1165

18. INFORMANT

ANNA M. ZELLINGER-WIFE

ADDRESS

SAME

ADDRESS  
APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

19.

412.4

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

0

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, form, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11-3-69

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

11/5/1969

24C. NAME OF CEMETERY or CREMATORY

OAK LAWN

24D. LOCATION (City, town, or county)

BALTO. CO., MD.

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 5 1969

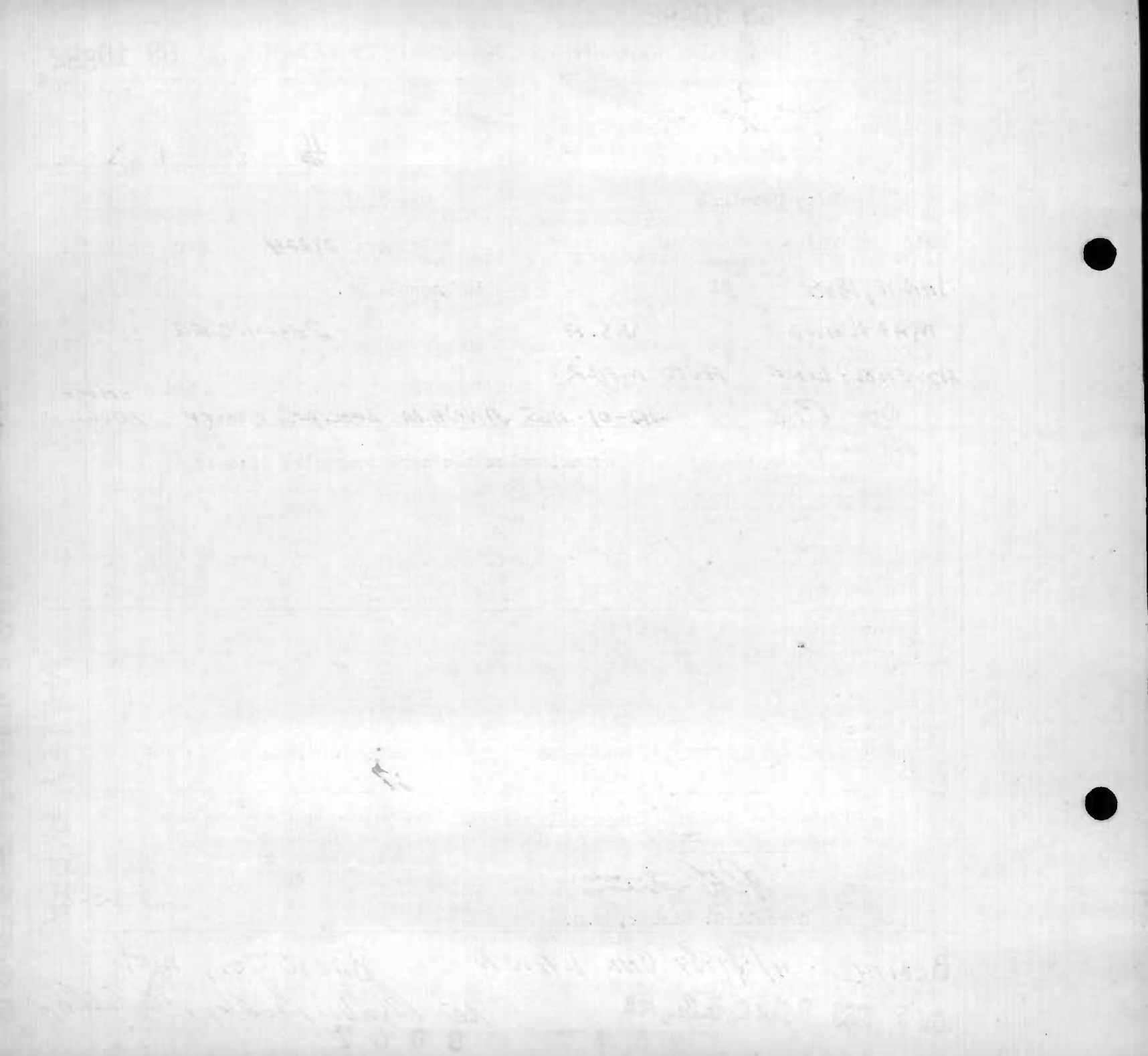
25B. NAME OF REGISTRAR

John E. Fisher, M.D.

25C. FUNERAL DIRECTOR

Rev. Bruce Roddy, Lordal Hotel

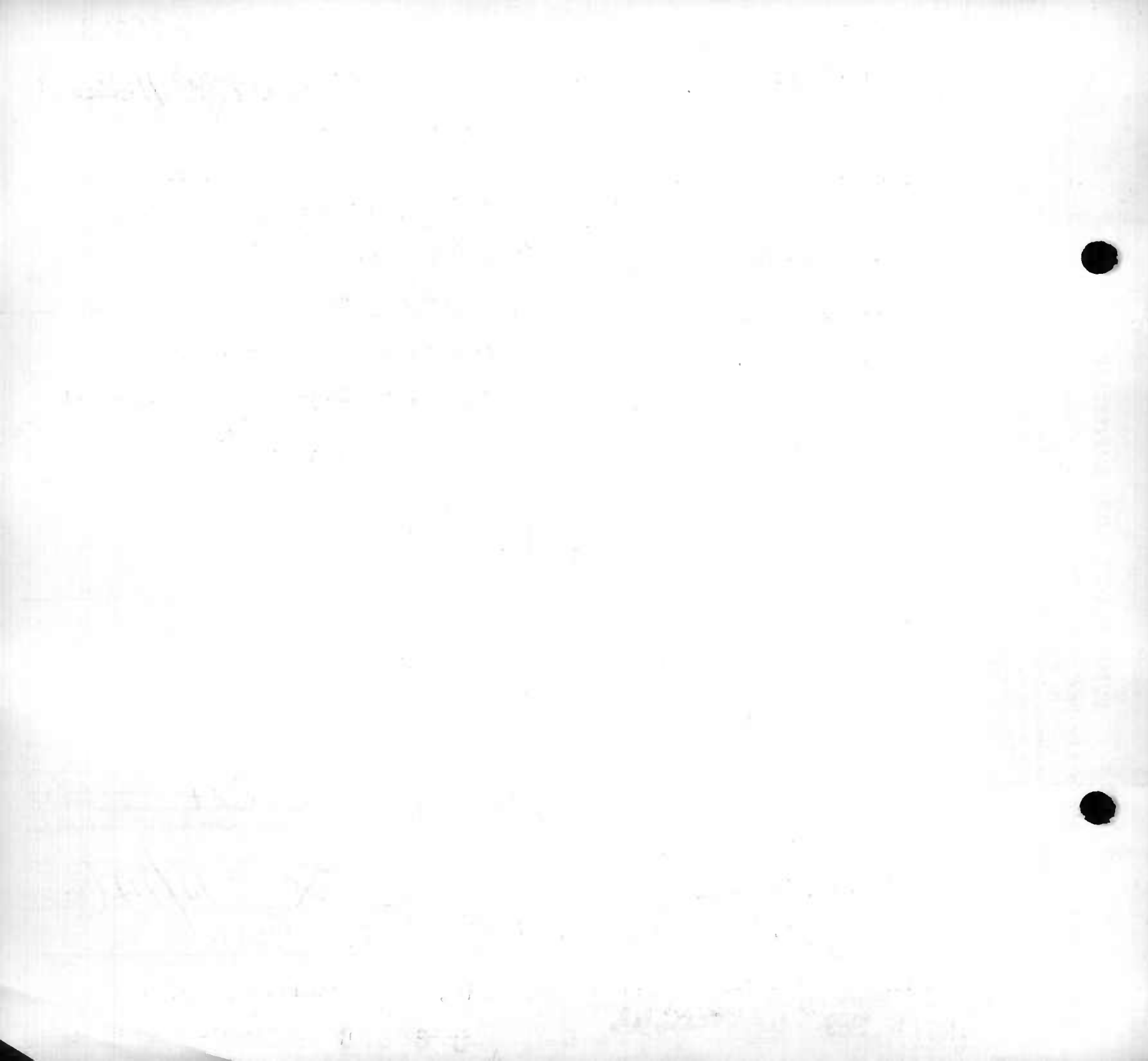
ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 5-530   |  | 69 10883   |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | REG. NO. 69 10883  |  |
| BIRTH NO.   |  |  |  | 1. NAME OF DECEASED<br>(Type or Print) <b>RICHARD W. SMITH</b>   |  |  |  |
| 2. DATE AND HOUR OF DEATH<br><b>10/14/69 11:25 A.M.</b>   |  |  |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>SINAI HOSP. BALT.</b>  |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                     |  | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <b>BALT.</b> B. COUNTY <b>PRINCE-GEORGES</b>   |  | 5. CITY OR TOWN<br><b>BALT.</b>  |  |
| 6. SEX<br><b>Male</b>   |  | 7. RACE<br><b>White</b>  |  | 8. DATE OF BIRTH<br><b>6-26-1951</b>   |  | 9. AGE (In years last birthday) <b>18</b>  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Student</b>   |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><b>JAPAN</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>Robert L. Smith</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>BARBARA RAMIREZ</b>   |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |  | 16. SOCIAL SECURITY NO.<br><b>NONE</b>   |  | 17. INFORMANT<br><b>MOTHER</b>   |  | ADDRESS<br><b>Barbara Ramirez-6509 Liberty Road #7</b>                             |  |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>UNDETERMINED</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| 19A. DATE OF OPERATION<br><b>10/14/69</b>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>PORTAL Hypert.</b>                |  | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>yes</b> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><b>NO</b>  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)  |  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX.)                       |  |
| 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?   |  | 22. I certify that (I) (this hospital) attended the deceased from <b>July 1969</b> to <b>Oct. 1969</b> that (I) (we) last saw the deceased alive on <b>Oct 12 1969</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |
| 23A. SIGNATURE<br><b>J. Soliman</b>   |  |  |  | 23B. DATE SIGNED<br><b>10/14/69</b>  |  | 23C. PHYSICIAN'S NAME (Type)<br><b>JOSEPH SOLIMAN M.D.</b>                         |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 24B. DATE<br><b>10-17-69</b>   |  | 24C. NAME of CEMETERY or CREMATORY<br><b>Baltimore National Cemetery</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>        |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 5 1969</b>  |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher</b>  |  | 25C. FUNERAL DIRECTOR<br><b>Ammaost Funeral Chapel</b>   |  | ADDRESS<br><b>4600 Liberty H</b>   |  |





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                  |   |  | REG. NO. <span style="float: right;">69 10884</span>                     |   |
|---|------------------|---|--|--|---|
| <div style="display: flex; justify-content: space-between;"> <span>5-312</span> <span>69 10884</span> <span>CERTIFICATE OF DEATH</span> </div>  |                  |   |  |  |   |
| BIRTH NO.   |                  | 1. NAME OF DECEASED<br>(Type or Print)  |  | 2. DATE AND HOUR OF DEATH  |   |
|   |                  | JOSEPH P. STUPAK  |  | November 3, 1969. 6:15 P. M.   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)  |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><br>31 Baltimore City Hospitals   |                  |   | A. STATE<br>Maryland   |  |   |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |                  |   | C. CITY OR TOWN<br>Baltimore   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|   |                  |   | E. STREET AND NUMBER<br>317 Hornel Street, 21224   |  |   |
| 5. SEX<br>Male  | 6. RACE<br>White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>11/26/04   | 9. AGE (In years last birthday)<br>64                                    | If Under 1 Yr. Months Days<br>If Under 24 Hrs. Hours Min.                                     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Pipefitter   |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>Shipbuilding   |  | 11. BIRTHPLACE (State or foreign country)<br>Pennsylvania                |   |
| 13. FATHER'S NAME<br>Louis Stupak   |                  |   | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No -  |                  |   | 16. SOCIAL SECURITY NO.<br>213-10-4066   |  | 17. INFORMANT<br>Mrs. Helen Stupak, 317 Hornel Street   |
| 18. <u>205.0 I</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                |                  |   | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><u>Acute myelogenous leukemia</u><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF: |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 mos.</u>                                 |
| MEDICAL CERTIFICATION   |                  |   |  |  |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                  |   |  |  |   |
| 19A. DATE OF OPERATION<br><u>0</u>  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><u>No</u>                                   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Aug. 32</u> 19 <u>69</u> to <u>Nov. 3</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Oct. 24</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death. |                  |   |  |  |   |
| 23A. SIGNATURE<br><u>Carroll L. Spurling, MD</u>  |                  |   | 23B. DATE SIGNED<br><u>Nov. 4, 1969</u>  |  |   |
| 23C. PHYSICIAN'S NAME (Type)<br>Carroll L. Spurling, M.D.   |                  |   | 23D. ADDRESS<br>University of Maryland Hospital<br>Baltimore, Maryland 21201   |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |                  | 24B. DATE   |  | 24C. NAME of CEMETERY or CREMATORY                                       |   |
| Burial  |                  | 11/6/69   |  | St. Stanislaus   |   |
| 24D. LOCATION (City, town, or county) (State)   |                  | 24E. LOCATION (City, town, or county) (State)   |  |  |   |
| Baltimore, Maryland   |                  | Baltimore, Maryland   |  |  |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 5 1969</u>  |                  | 25B. NAME OF REGISTRAR<br><u>John E. Kelly, Jr.</u>   |  | 25C. FUNERAL DIRECTOR<br>M. F. SADOWSKI & SONS, 1808 EASTERN AVE.        |   |

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George Washington

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Aug. 24

Oct. 21

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George Washington

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

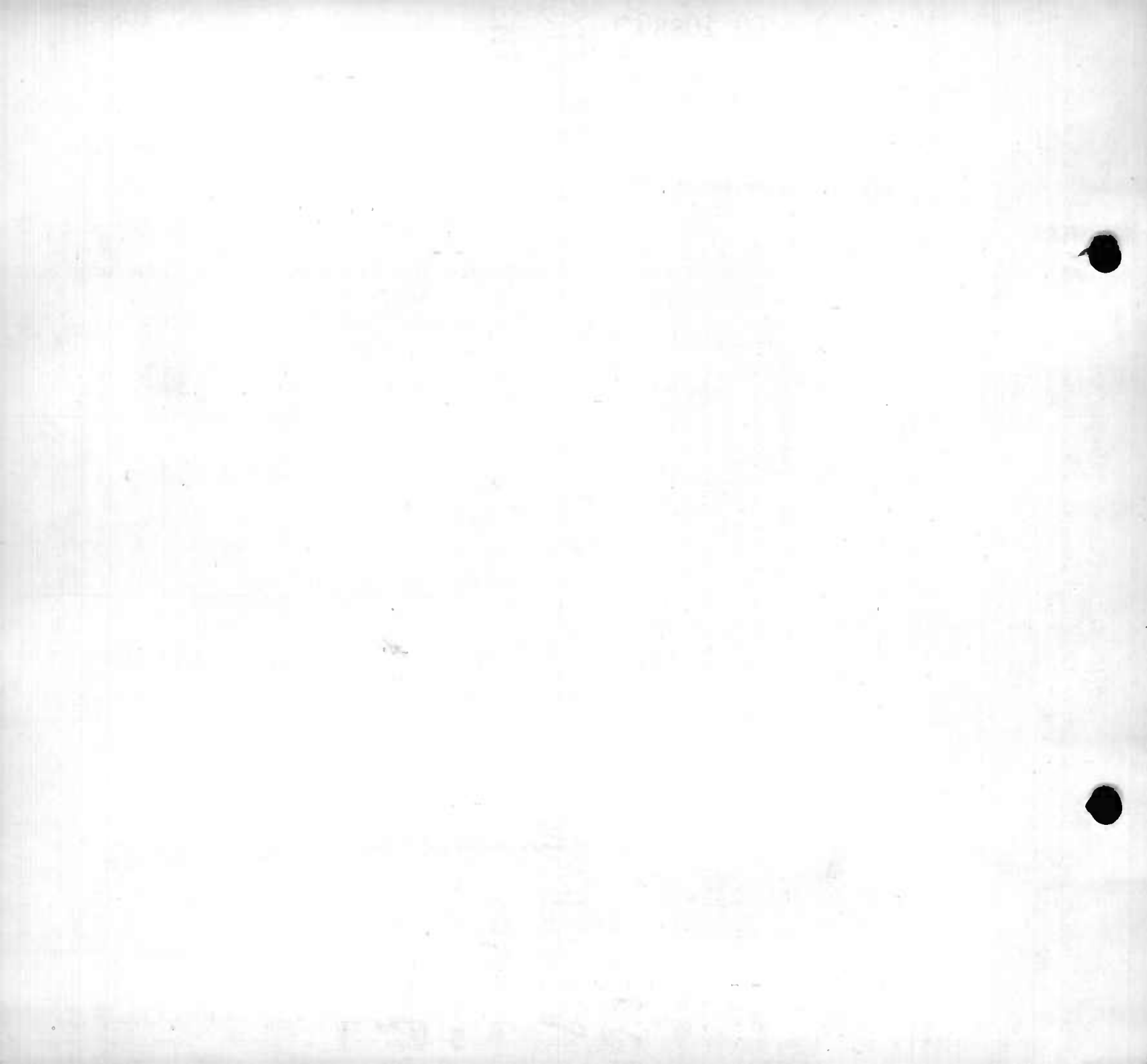
|  |  |  |  |
|--|--|--|--|
| <div style="display: flex; justify-content: space-between;"> <span>M-625</span> <span>69 10885</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>   |  | REG. NO. <span style="font-size: 2em;">411</span><br><span style="font-size: 2em;">69 10885</span>   |  |
| BIRTH NO. <span style="font-size: 1.5em;">11-25</span>   |  | 1. NAME OF DECEASED<br>(Type or Print) <span style="font-size: 1.2em;">MURCHINSON, Nannie</span>   |  |
| 2. DATE AND HOUR OF DEATH<br><span style="font-size: 1.2em;">10-30-69</span> <span style="float: right;">6 P.M.</span>   |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><span style="font-size: 1.2em;">George Washington Nursing Home<br/>607 Penn Ave.</span> |  |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <span style="font-size: 1.2em;">Maryland</span><br>B. COUNTY <span style="font-size: 1.2em;">Baltimore</span>  |  | C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| E. STREET AND NUMBER<br><span style="font-size: 1.2em;">200 1/2 McCulloch St.</span>   |  | 5. SEX <span style="font-size: 1.2em;">Female</span> 6. RACE <span style="font-size: 1.2em;">Negro</span>  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <span style="font-size: 1.2em;">8-14-1900</span> 9. AGE (In years, lost birthday) <span style="font-size: 1.2em;">69 yrs</span>   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><span style="font-size: 1.2em;">Unknown</span>  |  | 10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">?</span>   |  |
| 11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">?</span>   |  | 12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">US</span>   |  |
| 13. FATHER'S NAME <span style="font-size: 1.2em;">Blue, Neal</span>  |  | 14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Christly Monroe</span>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><span style="font-size: 1.2em;">No</span>  |  | 16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">?</span>   |  |
| 17. INFORMANT <span style="font-size: 1.2em;">Mrs. Louise Monroe</span>  |  | ADDRESS <span style="font-size: 1.2em;">2100 1/2 McCulloch Ave</span>  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><span style="font-size: 1.2em;">Arteriosclerotic Cardiovascular Disease</span>   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><span style="font-size: 1.2em;">Years</span>   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><span style="font-size: 1.2em;">Generalized Arteriosclerosis</span>  |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C)  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><span style="font-size: 1.2em;">Subarachnoid Hemorrhage</span>   |  | MEDICAL CERTIFICATION  |  |
| 19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">NO</span>  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  |  |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) <del>(myself)</del> attended the deceased from <span style="font-size: 1.2em;">19 May</span> <span style="font-size: 1.2em;">19 69</span> to <span style="font-size: 1.2em;">30 October</span> <span style="font-size: 1.2em;">19 69</span> , that (I) <del>(we)</del> last saw the deceased alive on <span style="font-size: 1.2em;">29 October</span> <span style="font-size: 1.2em;">19 69</span> and that in (my) <del>(my)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(did)</del> view the body after death. |  |  |  |
| 23A. SIGNATURE <span style="font-size: 1.2em;">Richard F. Tyson, M.D.</span>   |  | 23B. DATE SIGNED <span style="font-size: 1.2em;">31 October 69</span>  |  |
| 23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Richard F. Tyson M.D.</span>  |  | 23D. ADDRESS <span style="font-size: 1.2em;">2320 Eutaw Place, Baltimore Md., 21217</span>   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>   |  | 24B. DATE <span style="font-size: 1.2em;">11/3/69</span>   |  |
| 24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Mt Auburn Cemetery</span>   |  | 24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore Md</span>  |  |
| 25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">NOV 5 1969</span>  |  | 25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor, M.D.</span>   |  |
| 25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Nutter Funeral Home</span>   |  | ADDRESS <span style="font-size: 1.2em;">3035 W. North Ave</span>   |  |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |   |   |   | REG. NO. <span style="float: right;">69 10886</span>                     |   |
|--|---|---|---|--|---|
| <div style="display: flex; justify-content: space-between;"> <span>1-520</span> <span>69 10886</span> <span>CERTIFICATE OF DEATH</span> </div>   |   |   |   |  |   |
| BIRTH NO. <span style="float: right;">M.</span>  |   |   |   |  |   |
| 1. NAME OF DECEASED<br>(Type or Print) <span style="float: right;">Daisy Bailey Jones</span>   |   |   | 2. DATE AND HOUR OF DEATH<br><span style="float: right;">10-31-69</span>  |  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |   |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)   |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |   |   | A. STATE <span style="float: right;">Md</span>  |  |   |
| 1219 W. Lafayette Ave.<br>Baltimore, Maryland  |   |   | C. CITY OR TOWN<br><span style="float: right;">Baltimore</span>   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|  |   |   | E. STREET AND NUMBER<br><span style="float: right;">1219 W. Lafayette Ave</span>  |  |   |
| 5. SEX<br><span style="float: right;">F</span>   | 6. RACE<br><span style="float: right;">N</span> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><span style="float: right;">1-5-83</span>   | 9. AGE (In years last birthday)<br><span style="float: right;">86</span> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><span style="float: right;">Teacher - Retired</span>  |   |   | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><span style="float: right;">Maryland</span>      |
| 12. CITIZEN OF WHAT COUNTRY?<br><span style="float: right;">USA</span>   |   |   | 13. FATHER'S NAME<br><span style="float: right;">Henry Bailey</span>  |  |   |
| 14. MOTHER'S MAIDEN NAME<br><span style="float: right;">Sarah Miller</span>  |   |   | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><span style="float: right;">No</span> |  |   |
| 16. SOCIAL SECURITY NO.<br><span style="float: right;">220-38-8619A</span>   |   |   | 17. INFORMANT ADDRESS<br><span style="float: right;">Mrs. Elsie Key Rt #2 Box 72 Arrookeek, Md</span>   |  |   |
| 18. CAUSE OF DEATH   |   |   |   |  |   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH   |   |   |   |  |   |
| (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)   |   |   |   |  |   |
| ANTECEDENT CAUSES  |   |   |   |  |   |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |   |   |   |  |   |
| <div style="display: flex; justify-content: space-between;"> <div> <p>18. 410.0 I</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="float: right;">Coronary occlusion</span></p> <p>(B) <span style="float: right;">AHC V</span></p> <p>(C) <span style="float: right;">Congestive heart failure</span></p> </div> <div> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p><span style="float: right;">?</span></p> <p><span style="float: right;">?</span></p> <p><span style="float: right;">?</span></p> </div> </div> |   |   |   |  |   |
| II   |   |   |   |  |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |   |   |   |  |   |
| 19A. DATE OF OPERATION <span style="float: right;">0 Nov</span>  |   |   |   |  |   |
| 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |   |  |   |
| 20A. AUTOPSY? (Yes or No) <span style="float: right;">no</span>  |   |   |   |  |   |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |   |   |   |  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |   |   |   |  |   |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |   |   |   |  |   |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |   |   |   |  |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)  |   |   |   |  |   |
| 21E. INJURY OCCURRED   |   |   |   |  |   |
| 21F. HOW DID INJURY OCCUR?   |   |   |   |  |   |
| 22. I certify that (I) (this hospital) attended the deceased from <span style="float: right;">19</span> to <span style="float: right;">Oct 29</span> 19 <span style="float: right;">69</span> , that (I) (we) last saw the deceased alive on <span style="float: right;">Oct. 29</span> 19 <span style="float: right;">69</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |   |   |   |  |   |
| 23A. SIGNATURE <span style="float: right;">George Mc Donald M.D.</span>  |   |   |   |  |   |
| 23B. DATE SIGNED <span style="float: right;">11/4/69</span>  |   |   |   |  |   |
| 23C. PHYSICIAN'S NAME (Type) <span style="float: right;">George Mc Donald</span>   |   |   |   |  |   |
| 23D. ADDRESS <span style="float: right;">844 N. Carey</span>   |   |   |   |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |   |   |   |  |   |
| 24B. DATE <span style="float: right;">11-4-69</span>   |   |   |   |  |   |
| 24C. NAME OF CEMETERY or CREMATORY <span style="float: right;">Arbutus Memorial Park</span>  |   |   |   |  |   |
| 24D. LOCATION (City, town, or county) (State) <span style="float: right;">Baltimore Md</span>  |   |   |   |  |   |
| 25A. DATE REC'D BY HEALTH DEPT. <span style="float: right;">NOV 5 1969</span>  |   |   |   |  |   |
| 25B. NAME OF REGISTRAR <span style="float: right;">Robert E. Taylor</span>   |   |   |   |  |   |
| 25C. FUNERAL DIRECTOR ADDRESS <span style="float: right;">Nutter Funeral Home 3035 W. North Ave.</span>  |   |   |   |  |   |



A-536

69 10887

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 10887

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ANNA M. ANDERSON

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

10 30

69

1:35 p. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Lutheran Hospital D.O.A.

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

Oct. 30, 1969

1:35 p. M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

Female

7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

4/23/1913

10. AGE (In years  
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1835 Walbrook Ave.

11. BIRTHPLACE (State or foreign country)

Texas

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Augustus Roberts

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housekeeper

14B. KIND OF BUSINESS OR INDUSTRY

Private Family

15. MOTHER'S MAIDEN NAME

Rosie Matthis

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

215-22-9943

18. INFORMANT

Mr. Robert Anderson 1835 Walbrook Ave

ADDRESS

19.

571.9

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

Cirrhosis of the liver

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Isidore Mihalakis, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/31/69

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

11/4/69

24C. NAME OF CEMETERY OR CREMATORY

Mt Auburn Cemetery

24D. LOCATION (City, town, or county)

Baltimore

(State)

Md

25A. DATE REC'D BY HEALTH DEPT.

NOV 5 1969

25B. NAME OF REGISTRAR

Robert E. Talley, M.D.

25C. FUNERAL DIRECTOR

Nutter Funeral Home

ADDRESS

3035 W. North Ave

1987

10-01-87

WALTER POLLOCK

1987-1988

1987-1988

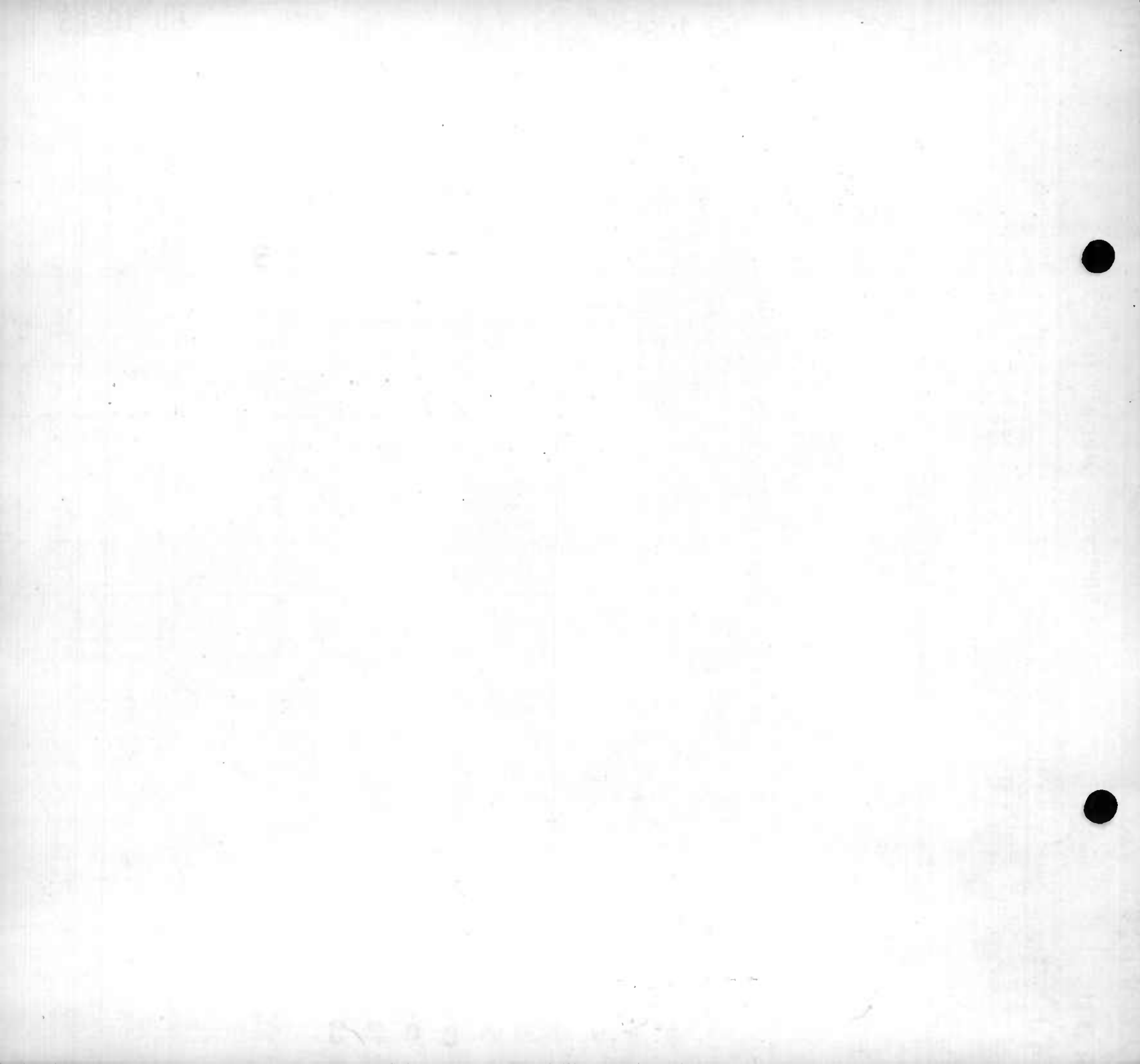
Office



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                             |   |   | REG. NO. <b>69 10888</b>  |   |
|---|-----------------------------|---|---|---|---|
| BIRTH NO. <b>R-152</b>  |                             | <b>69 10888</b>   |   | <b>CERTIFICATE OF DEATH</b>   |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>ANNA ROBINSON</b>   |                             |   | 2. DATE AND HOUR OF DEATH<br><b>OCT. 31-1969 1230 P.M.</b>  |   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                             |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)   |   |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>4009 Liberty Heights Ave</b>   |                             |   | A. STATE <b>MARYLAND</b><br>B. COUNTY <b>1605</b>   |   |   |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>00 Baltimore Md 21207</b>  |                             |   | C. CITY OR TOWN<br><b>BALTIMORE</b>   |   | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| E. STREET AND NUMBER<br><b>2658 W. FRANKLIN ST.</b>   |                             |   |   |   |   |
| 5. SEX<br><b>FEMALE</b>   | 6. RACE<br><b>NEGRO</b>     | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5-9-76</b>   | 9. AGE (In years last birthday)<br><b>93</b>  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>DOMESTIC</b>  |                             | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Pvt Family</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>Va</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |
| 13. FATHER'S NAME<br><b>?</b>   |                             |   | 14. MOTHER'S MAIDEN NAME<br><b>Lucy Robinson</b>  |   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                             | 16. SOCIAL SECURITY NO.<br><b>215-12-037741</b>   | 17. INFORMANT <b>Mrs. Mary Osborne</b> ADDRESS <b>2658 W. Franklin</b>  |   |   |
| 18. <b>412.41</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Arteriosclerotic Cardio -</b><br><b>Antecedent Causes</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Rescular Disease</b> |                             |   | CAUSE OF DEATH<br><b>Arteriosclerotic Cardio -</b><br><b>Rescular Disease</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                             |   |   |   |   |
| 19A. DATE OF OPERATION<br><b>0</b>  |                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)<br><b>No</b>  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                             | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |   | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>Oct 31</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                             |   |   |   |   |
| 23A. SIGNATURE<br><b>Louis T. Lavy M.D.</b>   |                             | 23B. DATE SIGNED<br><b>Nov 2-1969</b>   |   | 23C. ADDRESS<br><b>3602 N. Rogers Ave Baltimore Md 21212</b>                          |   |
| 23D. PHYSICIAN'S NAME (Type)<br><b>LOUIS T. LAVY M.D.</b>   |                             | 23E. ADDRESS<br><b>3602 N. Rogers Ave Baltimore Md 21212</b>  |   |   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 24B. DATE<br><b>11-5-69</b> | 24C. NAME of CEMETERY or CREMATORY<br><b>Mt Auburn Cemetery</b>   |   | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore Md</b>                  |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 5 1969</b>  |                             | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor M.D.</b>  |   | 25C. FUNERAL DIRECTOR<br><b>Nutter Funeral Home</b> ADDRESS <b>3035 W. North Ave.</b> |   |



# FUNERAL DIRECTOR: IMPORTANT

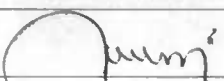
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

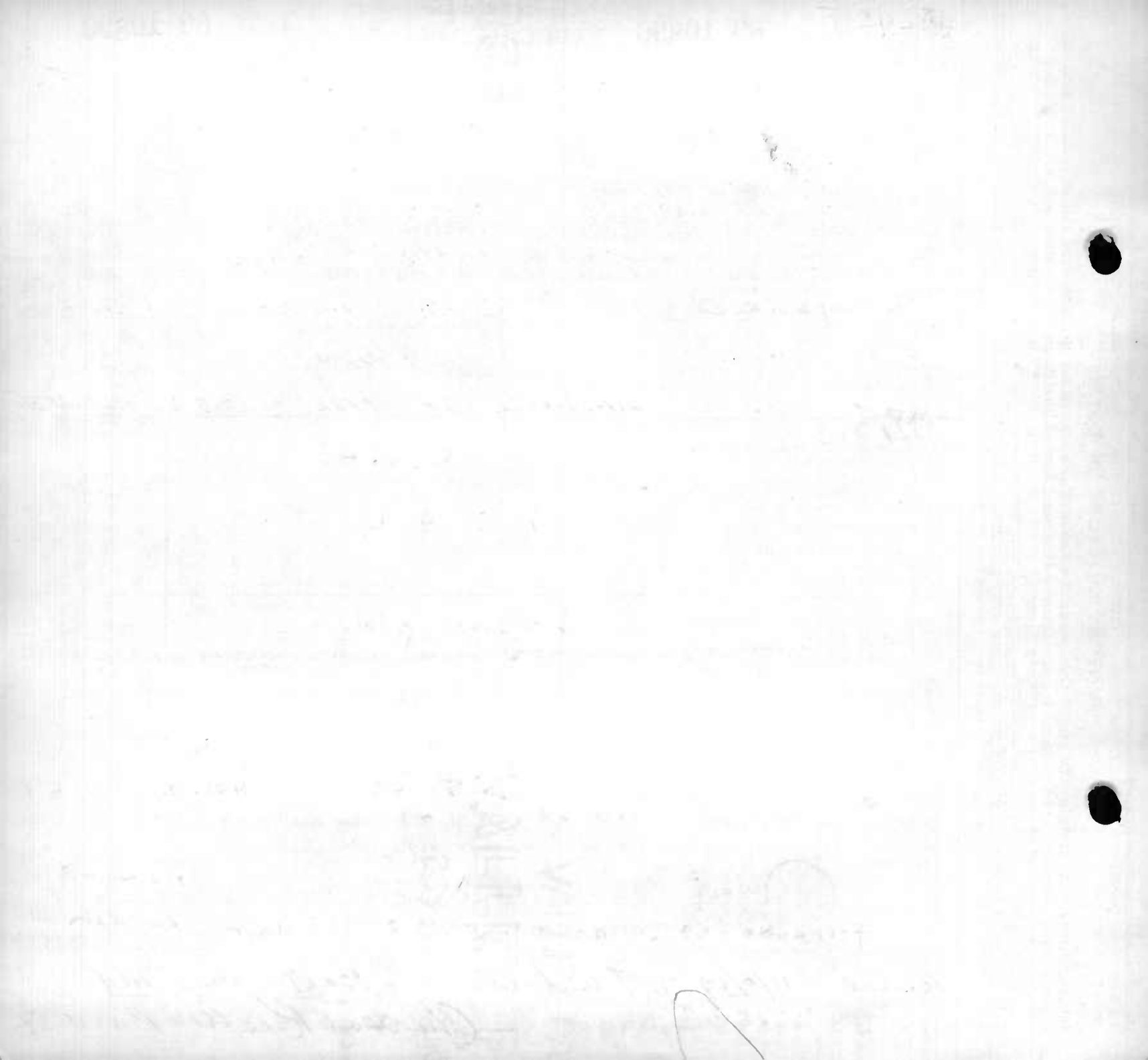
| BALTIMORE CITY HEALTH DEPARTMENT  |         |  |   | REG. NO. <b>69 10889</b>   |   |
|---|---------|--|---|--|---|
| H-400   |         | 69 10889   |   | CERTIFICATE OF DEATH   |   |
| BIRTH NO.   |         | 1. NAME OF DECEASED<br>(Type or Print)   |   | 2. DATE AND HOUR OF DEATH  |   |
|   |         | EDGAR D. HALL  |   | October 31, 1969 11 50 A M.  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |         |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                             |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |         |  | A. STATE  |  |   |
|   |         |  | B. COUNTY   |  |   |
| JOHNS HOPKINS HOSPITAL  |         |  | C. CITY OR TOWN   |  | D. INSIDE CITY LIMITS?  |
|   |         |  | BALTIMORE   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|   |         |  | E. STREET AND NUMBER  |  |   |
|   |         |  | 3320 BRIGHTON STREET 16 07  |  |   |
| 5. SEX  | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>        | 8. DATE OF BIRTH  | 9. AGE (In years last birthday)  | 10. Under 1 Yr. Months Days   |
| MALE  | NEGRO   | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                           | May 17, 1889  | 80   |   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |         | 10B. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)                                |   |
| METHODIST PREACHER  |         |  |   | Gallatin, Tennessee  |   |
| 13. FATHER'S NAME   |         |  | 14. MOTHER'S MAIDEN NAME  |  |   |
| HARBY HALL  |         |  | WALLACE BRACKEN   |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |         | 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT  |   |
| No  |         | 224-48-6231  |   | JUANITA H. DAVIS (WIFE) 3212 WALBROOK AVE                                |   |
| 18. CAUSE OF DEATH  |         |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |         |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:   |  |   |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  |         |  | Disseminated carcinomatosis 6 years   |  |   |
| ANTECEDENT CAUSES   |         |  | (B) DUE TO, OR AS A CONSEQUENCE OF:   |  |   |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |         |  | Adenocarcinoma of the prostate 6 years  |  |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |         |  | (C) SEVERE LIVER INVOLVEMENT + probable brain involvement - (possible intercranial hemorrhage terminally) 6 years |  |   |
| 19A. DATE OF OPERATION  |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No)  |   |
| 2 NONE  |         | NONE   |   | YES  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)     |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| NO  |         | NONE   |   | NONE   |   |
| 21D. TIME OF INJURY (APPROX.)   |         | 21E. INJURY OCCURRED   |   | 21F. HOW DID INJURY OCCUR?   |   |
| NONE  |         | While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> |   | NONE   |   |
| 22. I certify that (1) (this hospital) attended the deceased from October 30 19 69 to October 31 19 69 that (1) (my) last saw the deceased alive on October 31 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. |         |  |   |  |   |
| 23A. SIGNATURE  |         |  |   | 23B. DATE SIGNED   |   |
| James W. Forster, M.D.  |         |  |   | October 31, 1969   |   |
| 23C. PHYSICIAN'S NAME (Type)  |         |  |   | 23D. ADDRESS   |   |
| JAMES W. FORSTER, M.D.  |         |  |   | JOHNS HOPKINS HOSPITAL   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |         | 24B. DATE  |   | 24C. NAME of CEMETERY or CREMATORY                                       |   |
| Burial  |         | 11/4/69  |   | Arbutus Memorial Park  |   |
|   |         |  |   | Baltimore Co Md  |   |
| 25A. DATE REC'D BY HEALTH DEPT.   |         | 25B. NAME OF REGISTRAR   |   | 25C. FUNERAL DIRECTOR  |   |
| NOV 5 1969  |         | Robert E. Taber, Jr.   |   | Nutter Funeral Home 3035 W. North Avenue                                 |   |



# FUNERAL DIRECTOR: IMPORTANT

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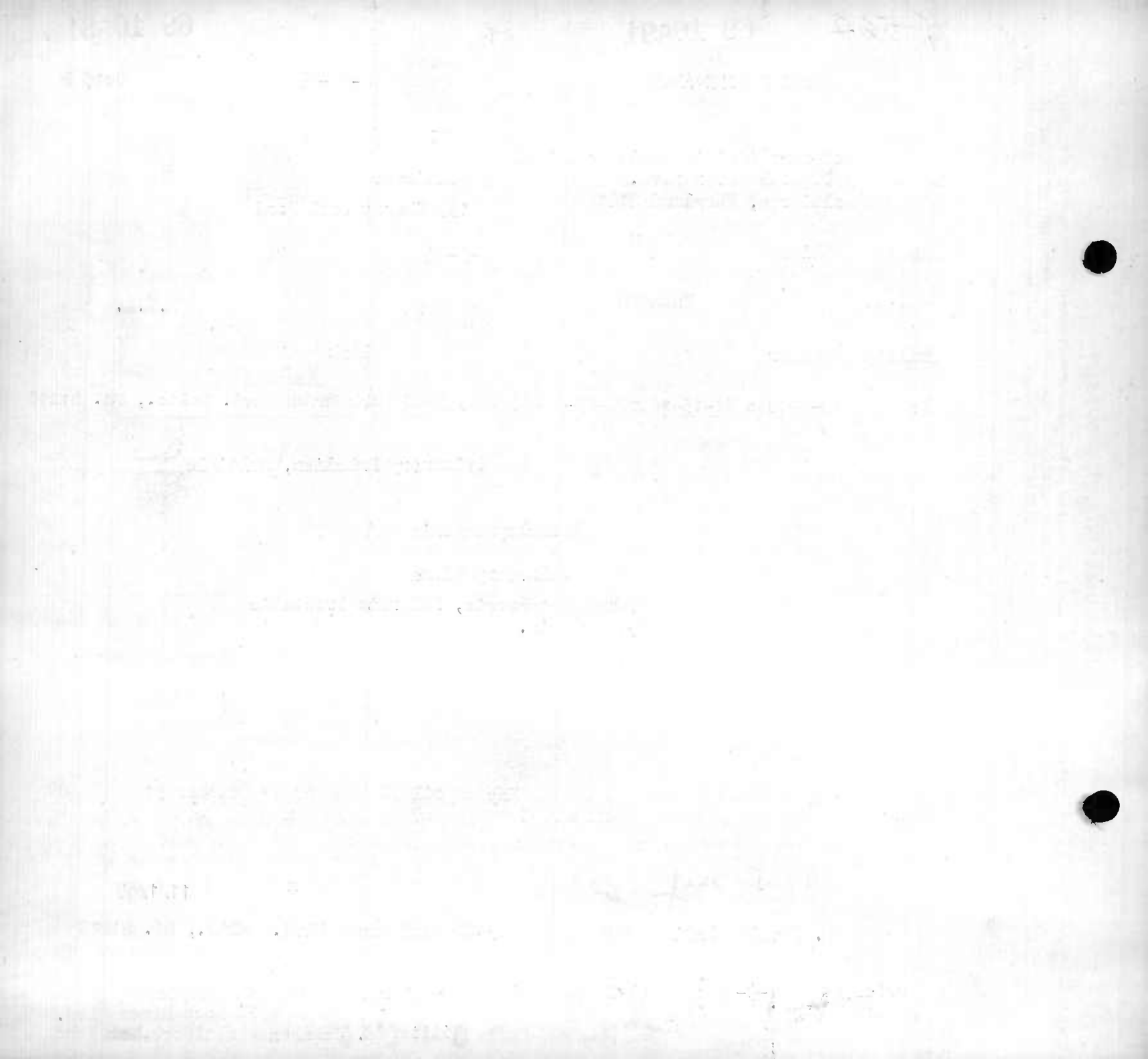
|  |  |   |  |
|--|--|---|--|
| <div style="display: flex; justify-content: space-between;"> <span>W-425</span> <span>69 10890</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <div style="text-align: center;"> <h2 style="margin: 0;">CERTIFICATE OF DEATH</h2> </div>   |  | REG. NO. <b>69 10890</b>  |  |
| BIRTH NO. _____  |  | 1. NAME OF DECEASED<br>(Type or Print) <b>LILA MAE WILSON</b>   |  |
| 2. DATE AND HOUR OF DEATH<br><b>NOVEMBER 2, 1969 4:45 A.M.</b>   |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>90 KEYCIRCLE HOSPICE</b><br><b>1214 EUTAW PLACE</b><br><b>BALTIMORE, MARYLAND 21217</b> |  |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b> 8. COUNTY <b>2101</b>  |  | C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| E. STREET AND NUMBER <b>815 BURGUNDY ST</b>  |  | 5. SEX <b>F</b> 6. RACE <b>C</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |
| 8. DATE OF BIRTH <b>9/03/10</b> 9. AGE (in years last birthday) <b>59 YRS</b>  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Factory Worker</b> 10B. KIND OF BUSINESS OR INDUSTRY _____  |  |
| 11. BIRTHPLACE (State or foreign country) <b>SOUTH CAROLINA</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>  |  | 13. FATHER'S NAME <b>ELI LEMONS</b> 14. MOTHER'S MAIDEN NAME <b>IDA DOW</b>   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>   |  | 16. SOCIAL SECURITY NO. <b>218-22-6052</b> 17. INFORMANT <b>IDA BELL</b> ADDRESS <b>213 S. HILTON ST</b>  |  |
| 18. <b>412.3 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>C. V. A.</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>A. S. H. D.</b> |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>C. V. A.</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>A. S. H. D.</b><br>(C) _____  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>Hypertension</b>  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____  |  |
| 19A. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____   |  | 20A. AUTOPSY? (Yes or No) _____ 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____  |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____   |  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) _____   |  |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR? _____  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10-23-69</b> 19 to <b>NOV. 2</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>10-23</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |  |   |  |
| 23A. SIGNATURE    |  | 23B. DATE SIGNED <b>11-4-69</b>   |  |
| 23C. PHYSICIAN'S NAME (Type) <b>Fernando B. Julian M.D.</b>  |  | 23D. ADDRESS <b>5428 Sinclair LA BALTO. MD 21206</b>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 24B. DATE <b>11/6/69</b>  |  |
| 24C. NAME OF CEMETERY OR CREMATORY <b>MT Auburn</b>  |  | 24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>   |  |
| 25A. DATE REC'D BY HEALTH DEPT. <b>NOV 5 1969</b>  |  | 25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>  |  |
| 25C. FUNERAL DIRECTOR <b>Charles A. Rice</b>   |  | ADDRESS <b>6614 Barre St</b>  |  |



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |   |  |  |
|--|---|--|--|
| BALTIMORE CITY HEALTH DEPARTMENT   |   | REG. NO. <b>69 10891</b>   |  |
| K-562 <b>69 10891</b>  |   | <b>CERTIFICATE OF DEATH</b>  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>KNORZER JOHN ADAM</b>  |   | 2. DATE AND HOUR OF DEATH<br><b>10-31-69 9:15 P</b> M.   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |   | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>23 Veterans Administration Hospital</b><br><b>3900 Loch Raven Blvd.</b><br><b>Baltimore, Maryland 21218</b>  |   | C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                  |  |
| 5. SEX <b>Male</b> 6. RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |   | 8. DATE OF BIRTH <b>9-3-94</b> 9. AGE (In years last birthday) <b>74</b>   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>   |   | 11. BIRTHPLACE (State or foreign country) <b>New York</b>  |  |
| 10B. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>   |   | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 13. FATHER'S NAME <b>Phillip Knoerzer</b>  |   | 14. MOTHER'S MAIDEN NAME <b>Link</b>   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 12-4-17 to 11-15-18</b>  |   | 16. SOCIAL SECURITY NO. <b>102-03-38-06</b>  |  |
| 17. INFORMANT <b>Records</b> ADDRESS <b>VAH, 3900 Loch Raven Blvd. Balto., Md. 21218</b>   |   |  |  |
| 18. <b>485X I</b> CAUSE OF DEATH   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Pulmonary Embolism, Multiple</b>  |   |  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>Bronchopneumonia</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>Pulmonary Edema</b>  |   |  |  |
| II <b>Hydropyonephrosis, Moderate Prostatic Hyperplasia.</b>   |   |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |   |  |  |
| 19A. DATE OF OPERATION   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20A. AUTOPSY? (Yes or No)  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?     |
|  |   |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)          | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |
|  |   |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |  |
|  |   |  |  |
| 22. I certify that <b>ON</b> (this hospital) attended the deceased from <b>May April 10</b> 19 <b>69</b> to <b>October 31</b> 19 <b>69</b> , that <b>we</b> last saw the deceased alive on <b>October 31</b> 19 <b>69</b> and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>ON</b> (We) (did) <b>not</b> view the body after death. |   |  |  |
| 23A. SIGNATURE <b>M. J. Shafi</b>  |   | 23B. DATE SIGNED <b>11/1/69</b>  |  |
| 23C. PHYSICIAN'S NAME (Type) <b>M. Javaid Shafi MD</b>   |   | 23D. ADDRESS <b>3900 Loch Raven Blvd. Balto., Md. 21218</b>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   | 24B. DATE <b>11-4-69</b>  | 24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cemetery</b>  | 24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b> |
| 25A. DATE REC'D BY HEALTH DEPT. <b>NOV 5 1969</b>  | 25B. NAME of REGISTRAR <b>John E. Johnson</b>   | 25C. FUNERAL DIRECTOR <b>8521 Loch Raven Blvd. Baltimore, Maryland</b>   |  |

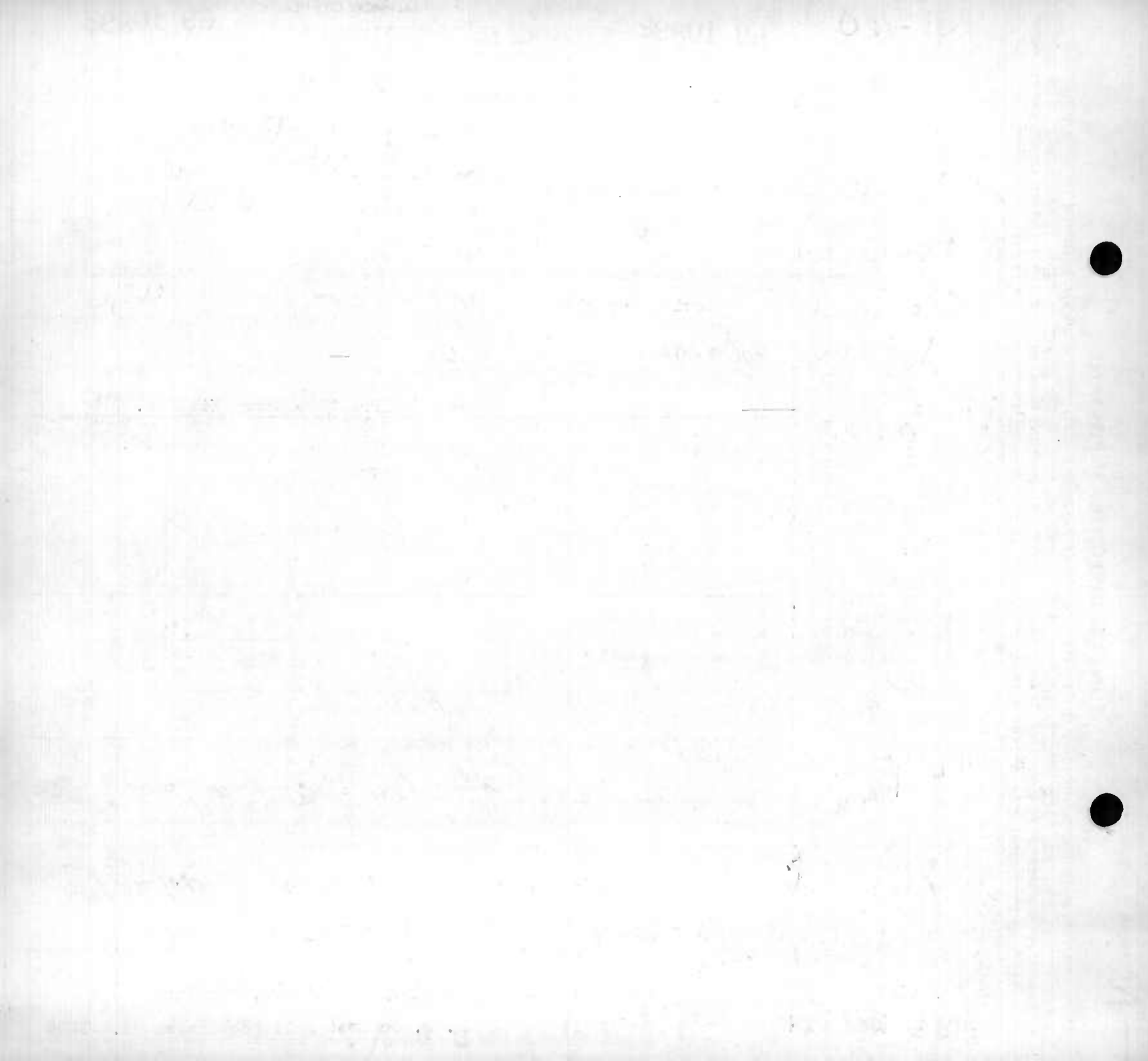




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

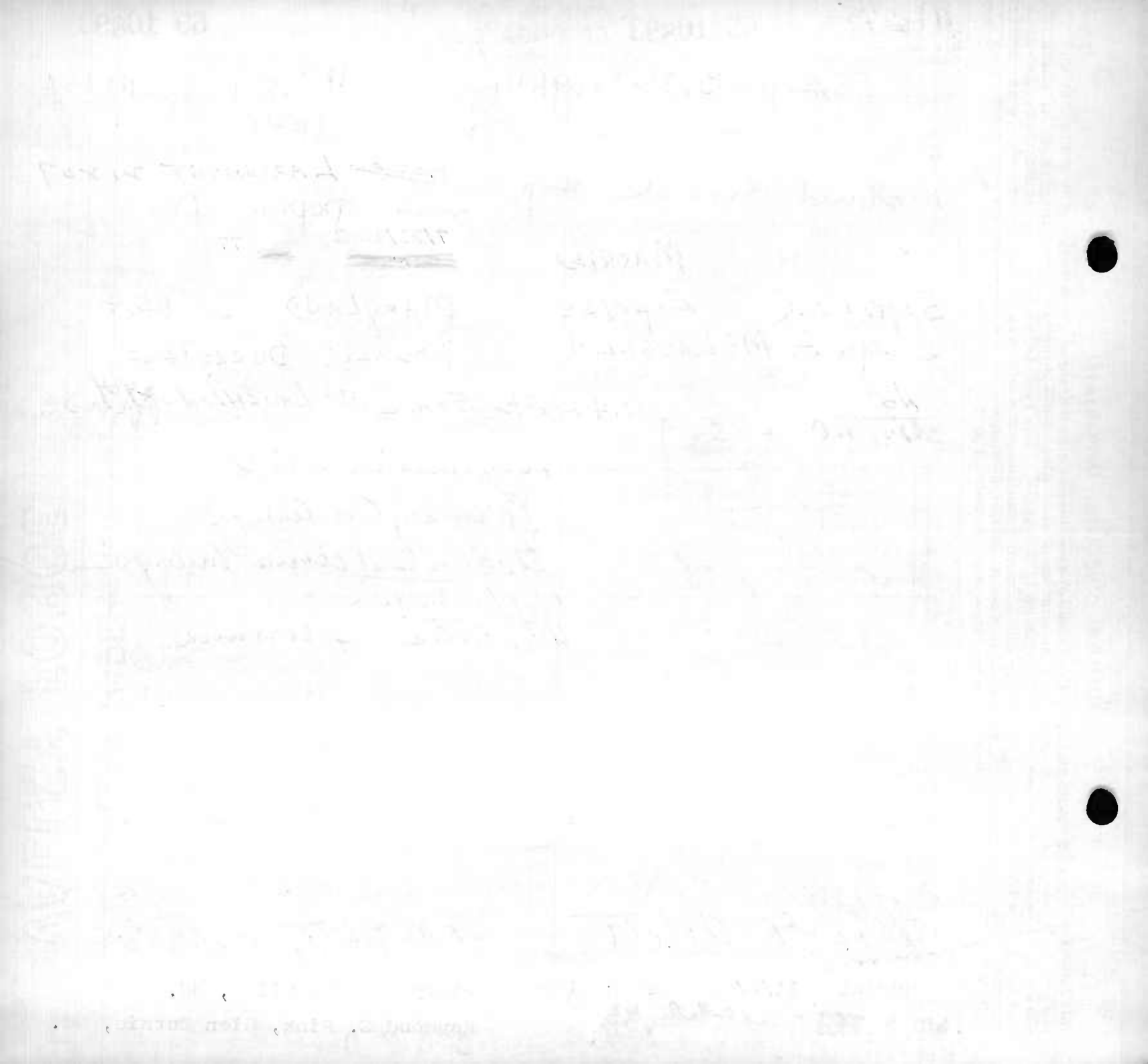
| J-160  |                         | 69 10892  |                                    | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. 69 10892   |  |
|--|-------------------------|---|------------------------------------|---|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Mary Jeffra</i>  |                         |   |                                    | 2. DATE AND HOUR OF DEATH<br><i>10/30/69</i> <i>10:30 A.M.</i>  |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><i>North Charles Gen Hosp</i>   |                         |   |                                    | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i><br>C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <i>204 Cherry Hill Road</i> |  |   |  |
| 5. SEX<br><i>Female</i>  | 6. RACE<br><i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>2/11/25</i> | 9. AGE (In years last birthday)<br><i>44</i>  | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Clerical</i>   |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Social Security</i>   |                                    | 11. BIRTHPLACE (State or foreign country)<br><i>MEXICO</i>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                   |  |
| 13. FATHER'S NAME<br><i>ALFONSO SANCHEZ</i>  |                         |   |                                    | 14. MOTHER'S MAIDEN NAME<br><i>Eliza</i>  |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <i>No</i>  |                         | 16. SOCIAL SECURITY NO.   |                                    | 17. INFORMANT ADDRESS<br><i>Joseph Jeffra 204 Cherry Hill Rd. 21136</i>   |  |   |  |
| 18. <i>250.9 I</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |                         |   |                                    | CAUSE OF DEATH<br><i>Massive pulmonary embolus</i>  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                    |  |
|  |                         |   |                                    | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:  |  |   |  |
|  |                         |   |                                    | (B) <i>Infections of thalamic lobe</i><br>DUE TO, OR AS A CONSEQUENCE OF:   |  |   |  |
| (C) <i>Diabetes</i>  |                         |   |                                    |   |  |   |  |
| MEDICAL CERTIFICATION  |                         |   |                                    |   |  |   |  |
| 19A. DATE OF OPERATION<br><i>2</i>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                    | 20A. AUTOPSY? (Yes or No) <i>yes</i>  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                                    | 21F. HOW DID INJURY OCCUR?  |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9/18/69</i> to <i>10/30</i> 19 <i>69</i><br>that (I) (we) lost saw the deceased alive on <i>19</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                         |   |                                    |   |  |   |  |
| 23A. SIGNATURE<br><i>Marino V. Patricio</i>  |                         |   |                                    | 23B. DATE SIGNED<br><i>10/30/69</i>   |  |   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><i>SPACIO V. PATRICIO</i>  |                         |   |                                    | 23D. ADDRESS<br><i>NCGH</i>   |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |                         | 24B. DATE<br><i>11/3/69</i>   |                                    | 24C. NAME OF CEMETERY or CREMATORY<br><i>Baltimore National Cemetery</i>  |  | 24D. LOCATION (City, town, or county) (State)<br><i>Baltimore, Maryland</i>     |  |
| 25A. DATE RECEIVED BY HEALTH DEPT.<br><i>NOV 5 1969</i>  |                         |   |                                    | 25B. NAME OF REGISTRAR<br><i>Wm. E. Johnson</i>   |  | 25C. FUNERAL DIRECTOR ADDRESS<br><i>8521 Loch Raven Bl. 21204</i>               |  |



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

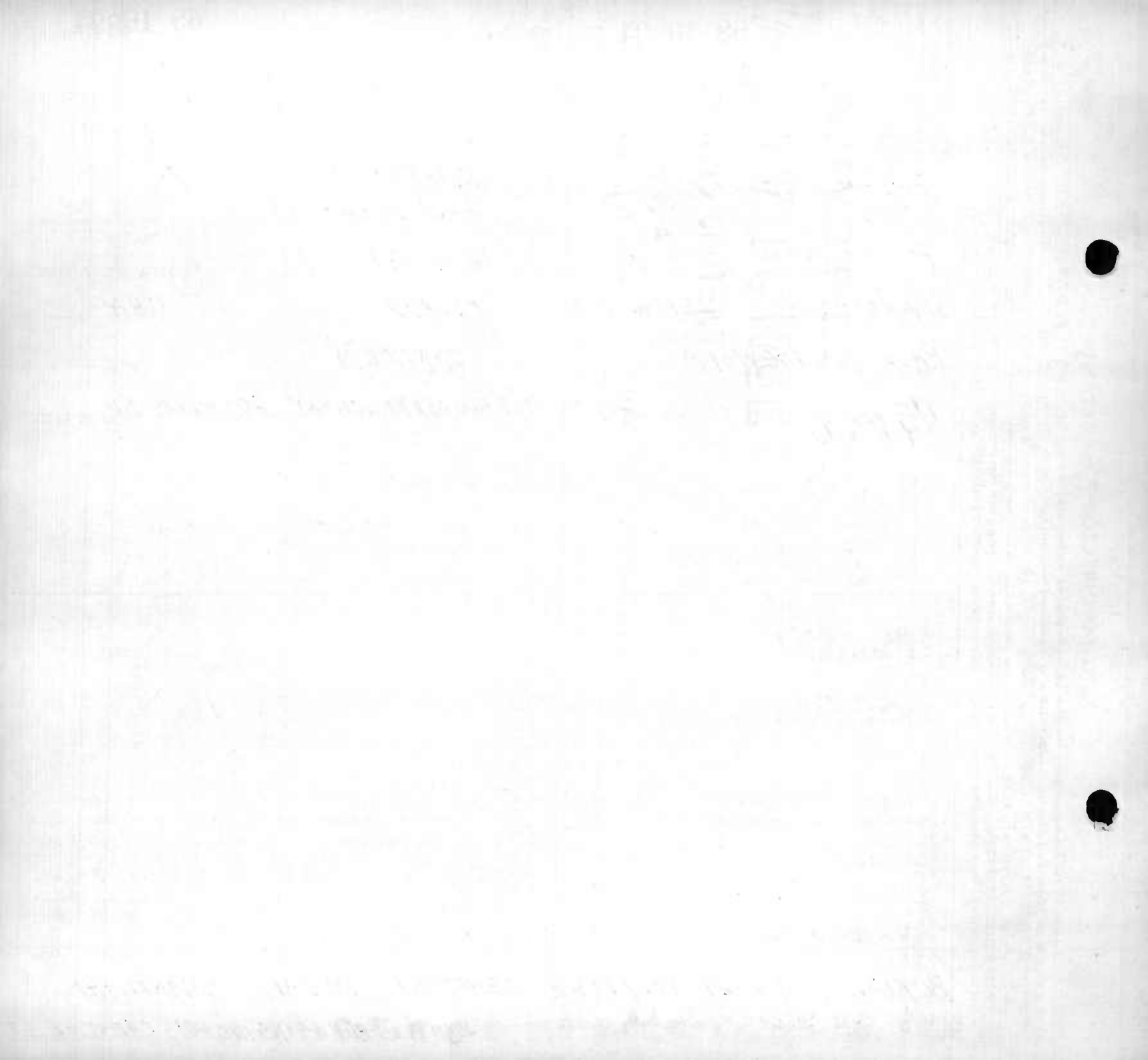
| BALTIMORE CITY HEALTH DEPARTMENT   |                  |  |  | Registered No. 69 10893   |  |
|--|------------------|--|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <u>Joseph B. McLaughlin</u>   |                  | 2. DATE AND HOUR OF DEATH<br><u>11/3/69</u> <u>11:35 A.M.</u>  |  |   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><u>Maryland General Hosp.</u>   |                  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <u>MD</u> B. COUNTY <u>Balto Co.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>5300</u><br><u>LARCHMONT 21207</u><br>D. STREET ADDRESS (If rural, give location) <u>2404 Poplar Dr.</u> |  |   |  |
| 5. SEX <u>M</u>  | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br><u>MARRIED</u>   | 8. DATE OF BIRTH <u>7/21/1892</u>  | 9. AGE (In years last birthday) <u>77</u>                                   | 10. Under 1 Yr. Months: Days               |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Supervisor</u>   |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Express</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>MARYLAND</u>                | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u> |
| 13. FATHER'S NAME<br><u>JOSEPH G. McLAUGHLIN</u>   |                  |  | 14. MOTHER'S MAIDEN NAME<br><u>ROSALIE BURROUGHS</u>   |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>  |                  | 16. SOCIAL SECURITY NO.<br><u>714-05-6894</u>  |  | 17. INFORMANT<br><u>ETHEL Mc LAUGHLIN</u><br>ADDRESS <u>2404 Poplar Dr.</u> |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><u>410.0 I + 250.9</u><br>(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                  |  | CAUSE OF DEATH<br>(A) <u>Regenerative C.V.D.</u><br>DUE TO<br>(B) <u>Coronary Occlusion</u><br>DUE TO<br>(C) <u>Abdominal Aortic Aneurysm</u><br><br><u>Hypertension</u><br><u>Diabetes &amp; Uremia</u> |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                  |  |  |   |  |
| 19A. DATE OF OPERATION<br><u>0</u>   |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)    |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10/20</u> 19 <u>69</u> to <u>11/3</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>11/3</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.               |                  |  |  |   |  |
| 23A. SIGNATURE<br><u>Michael J. Fink</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>  |                  |  |  | 23B. DATE SIGNED<br><u>11/3/69</u>  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>Thos J. Abbott</u>  |                  |  |  | 23D. ADDRESS<br>M.D. <u>4509 Liberty Heights Ave</u>                        |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                  | 24B. DATE<br><u>11/6/69</u>  |  | 24C. NAME OF CEMETERY or CREMATORY<br><u>Druid Ridge Cemetery</u>           |  |
|  |                  |  |  | 24D. LOCATION<br><u>Pikesville, Md.</u> (State)                             |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 5 1969</u>   |                  | 25B. NAME OF REGISTRAR<br><u>Thos J. Abbott</u>  |  | 25C. FUNERAL DIRECTOR<br><u>Raymond C. Fink, Glen Burnie, Md.</u>           |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

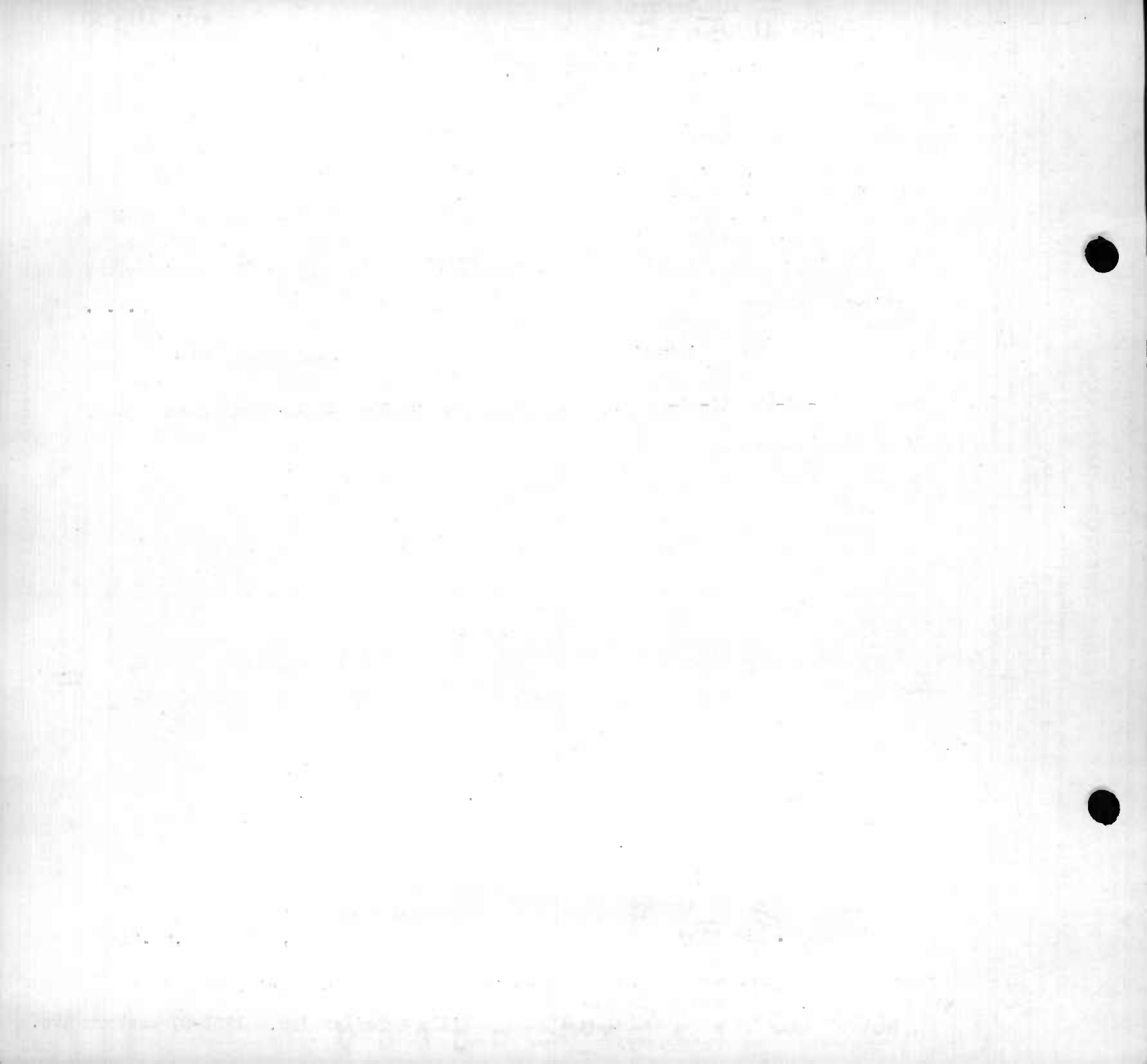
| BALTIMORE CITY HEALTH DEPARTMENT   |                            |   |  | REG. NO. <b>69 10894</b>   |  |
|--|----------------------------|---|--|--|--|
| <b>BIRTH NO.</b><br><b>1. NAME OF DECEASED</b><br>(Type or Print) <b>ALBINA K. KOZLOWSKI</b>   |                            | <b>69 10894 CERTIFICATE OF DEATH</b><br><b>2. DATE AND HOUR OF DEATH</b><br><b>11-3-69</b>  |  |  |  |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><br><b>FULL NAME OF HOSPITAL OR INSTITUTION</b><br><b>2212 GOUGH ST.</b><br><b>00</b>   |                            | <b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission)<br><b>A. STATE</b> <b>MARYLAND</b> <b>B. COUNTY</b> <b>105</b><br><b>C. CITY OR TOWN</b> <b>BALTIMORE</b> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br><b>E. STREET AND NUMBER</b> <b>2212 GOUGH ST.</b> |  |  |  |
| <b>5. SEX</b><br><b>F</b>  | <b>6. RACE</b><br><b>W</b> | <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>   | <b>8. DATE OF BIRTH</b><br><b>12-15-1895</b> | <b>9. AGE</b> (In years lost birthday)<br><b>73</b>                      | <b>If Under 1 Yr.</b> Months _____ <b>Days</b> _____ <b>If Under 24 Hrs.</b> Hours _____ <b>Min.</b> _____ |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>SEAMSTRESS</b>  |                            | <b>10B. KIND OF BUSINESS OR INDUSTRY</b><br><b>LEBOW BROS.</b>  |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>POLAND</b>        |  |
| <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>USA</b>  |                            | <b>13. FATHER'S NAME</b><br><b>PAUL KALINOWSKA</b>  |  |  |  |
| <b>14. MOTHER'S MAIDEN NAME</b><br><b>UNKNOWN</b>  |                            | <b>15. Was Deceased Ever in U. S. Armed Forces?</b><br>(Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |  |  |  |
| <b>16. SOCIAL SECURITY NO.</b><br><b>217-05-7017</b>   |                            | <b>17. INFORMANT</b> <b>EDWARD KOZLOWSKI</b> <b>ADDRESS</b> <b>209 GLEN RD</b>  |  |  |  |
| <b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                            | <b>CAUSE OF DEATH</b><br><b>(A) IMMEDIATE CAUSE</b> <i>Myocardial Infarct</i><br><b>DUE TO, OR AS A CONSEQUENCE OF:</b><br><br><b>(B) <i>Hypertensive Cardio-Vascular Disease</i></b><br><b>DUE TO, OR AS A CONSEQUENCE OF:</b><br><br><b>(C) _____</b>   |  |  |  |
| <b>II</b><br><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>   |                            |   |  |  |  |
| <b>19A. DATE OF OPERATION</b><br><b>0</b>  |                            | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>   |  | <b>20A. AUTOPSY? (Yes or No)</b>   |  |
| <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>  |                            | <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>   |  |  |  |
| <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                            | <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)   |  | <b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)                   |  |
| <b>21E. INJURY OCCURRED</b><br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                            | <b>21F. HOW DID INJURY OCCUR?</b>   |  |  |  |
| <b>22. I certify that (I) (this hospital) attended the deceased from <u>5/9/1969</u> to <u>11/3/69</u> 19<u>69</u>, that (I) (we) last saw the deceased alive on <u>5/9/1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>          |                            |   |  |  |  |
| <b>23A. SIGNATURE</b><br><i>Conrad Kurkowski, M.D.</i>   |                            |   |  | <b>23B. DATE SIGNED</b><br><b>11/4/69</b>                                |  |
| <b>23C. PHYSICIAN'S NAME (Type)</b><br><b>Andrew Kurkowski, M.D.</b>   |                            |   |  | <b>23D. ADDRESS</b><br><b>2529 Eastern Ave</b>                           |  |
| <b>24A. BURIAL CREMATION, REMOVAL (Specify)</b><br><b>BURIAL</b>   |                            | <b>24B. DATE</b><br><b>11-6-69</b>  |  | <b>24C. NAME OF CEMETERY or CREMATORY</b><br><b>HOLY ROSARY CEMETERY</b> |  |
| <b>24D. LOCATION</b> (City, town, or county) (State)<br><b>DUNDALK MARYLAND</b>  |                            | <b>25A. DATE REC'D BY HEALTH DEPT.</b><br><b>NOV 5 1969</b>   |  |  |  |
| <b>25B. NAME OF REGISTRAR</b><br><b>Robert E. Taylor</b>   |                            | <b>25C. FUNERAL DIRECTOR</b><br><b>JOHN A. WEBER &amp; SONS INC 4015 CHESTER ST</b>   |  |  |  |



|   |  |   |  |   |   |
|---|--|---|--|---|---|
| BIRTH NO.   |  | 1. NAME OF DECEASED<br>(Type or Print) <b>CHRISTOPHER LIGHTNING Sr.</b>                                   |  | 2. DATE AND HOUR OF DEATH<br><b>11/4/69</b> <b>10<sup>30</sup> A.M.</b>                       |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>2664</b>   |   |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>31 Baltimore City Hospitals<br/>4940 Eastern Avenue<br/>Baltimore, Maryland 21224</b>  |  |   | C. CITY OR TOWN<br><b>Baltimore</b>  |   | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |
| 5. SEX<br><b>Male</b>   |  |   | 6. RACE<br><b>White</b>  |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Laborer</b>   |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 8. DATE OF BIRTH<br><b>8-15-1924</b>  | 9. AGE (In years last birthday)<br><b>45</b>  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |   |
| 13. FATHER'S NAME<br><b>Andrew Lightning</b>  |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Georganna Ruth</b>  |   |   |
| 15. Was Deceased Ever in U. S. Armed Forces?<br>(Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes 10-23-43 11-21-44</b>   |  | 16. SOCIAL SECURITY NO.<br><b>220-14-2467</b>   |  | 17. INFORMANT<br><b>Records: BCH-4940 Eastern Avenue 21224</b>                                |   |
| 18. <b>486X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.)<br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>PULMONARY EMPHYSEMA</b> |  |   | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br><b>PNEUMONIA</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <b>ASPIRATION</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>8 HRS.</b><br><b>8 HRS.</b><br><b>6 HRS.</b> |   |   |
| 19A. DATE OF OPERATION<br><b>2</b>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><b>YES</b>   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>11/4</b> <b>19 69</b> to <b>11/4</b> <b>19 69</b> , that (I) (we) lost saw the deceased alive on <b>11/4</b> <b>19 69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |  |   |  |   |   |
| 23A. SIGNATURE<br><b>Dennis W. Bleakley M.D.</b>  |  |   |  | 23B. DATE SIGNED<br><b>11/4/69</b>  |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Dennis W. Bleakley</b>   |  |   |  | 23D. ADDRESS<br><b>Baltimore City Hospitals<br/>4940 Eastern Avenue, Baltimore, Md. 21224</b> |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 24B. DATE<br><b>11-7-1969</b>   |  | 24C. NAME of CEMETERY or CREMATORY<br><b>Glen Haven Memorial Park</b>                         |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>Glen Burnie, Maryland</b>   |  | 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 5 1969</b>  |  |   |   |
| 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>   |  | 25C. FUNERAL DIRECTOR ADDRESS<br><b>Lilly &amp; Zeiler Inc. 1901-07 Eastern Ave.</b>                      |  |   |   |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.





**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                  |   |                                    | REG. NO. <b>69 10896</b>   |
|---|------------------|---|------------------------------------|--|
| N-240   |                  | 69 10896 CERTIFICATE OF DEATH   |                                    |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>John W. Nagel</b>   |                  | 2. DATE AND HOUR OF DEATH<br><b>2:14 AM 11/3/69</b>   |                                    |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>The Johns Hopkins Hospital</b>  |                  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>Baltimore</b><br>C. CITY OR TOWN <b>Baltimore</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>825 Freeman Street</b> |                                    |  |
| 5. SEX <b>M</b>   | 6. RACE <b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>8/28/90</b> | 9. AGE (In years last birthday) <b>79</b>  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Bus Driver</b>  |                  | 10B. KIND OF BUSINESS OR INDUSTRY   |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore Maryland</b>             |
| 13. FATHER'S NAME<br><b>Jacob Nagel</b>   |                  | 14. MOTHER'S MAIDEN NAME<br><b>Margaret Blankenheim</b>   |                                    |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |                  | 16. SOCIAL SECURITY NO.<br><b>213-05-9285</b>   |                                    | 17. INFORMANT ADDRESS<br><b>Mr. Edward W. Nagel 324 Torner Road 21221</b>          |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)<br><b>Cardio Respiratory Arrest</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.<br><b>Metabolic Acidosis</b> |                  |   |                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                       |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |                  |   |                                    |  |
| 19A. DATE OF OPERATION  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                    | 20A. AUTOPSY? (Yes or No) <b>YES</b>   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <b>No</b>   |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>No</b> |
| 21D. TIME OF INJURY (APPROX.)   |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                                    | 21F. HOW DID INJURY OCCUR?   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>9/16/69</b> to <b>11/3/69</b> , that (I) (we) last saw the deceased alive on <b>11/3 2:14 AM 69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                  |   |                                    |  |
| 23A. SIGNATURE<br><b>R. Saral M.D.</b>  |                  | 23B. DATE SIGNED<br><b>11/3</b>   |                                    | 23C. PHYSICIAN'S NAME (Type)<br><b>Rein Saral, M.D.</b>                            |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                  | 24B. DATE<br><b>11/6/69</b>   |                                    | 24C. NAME OF CEMETERY or CREMATORY<br><b>Moreland Memorial Park</b>                |
| 24D. LOCATION (City, town, or county)<br><b>Baltimore Maryland</b>  |                  | 24E. STATE<br><b>Maryland</b>   |                                    |  |
| 25A. DATE REC'D BY THE DEPT.<br><b>NOV 5 1969</b>   |                  | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor</b>   |                                    | 25C. FUNERAL DIRECTOR<br><b>Logan J. Ruck Inc.</b>                                 |
| 25D. ADDRESS<br><b>3305 HANCOCK RD.</b>   |                  |   |                                    |  |

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |  |  |   |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|
| L-500   |  | 69 10897   |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | X  |  | 69 10897                                     |  |
| BIRTH NO.   |  | 1. NAME OF DECEASED<br>(Type or Print)   |  | 2. DATE AND HOUR OF DEATH   |  | REG. NO.   |  |  |  |
|   |  | Mattie Lane  |  | Nov 1, 1969   |  | 538  |  | A.M.   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |  |  |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |  |  |  | A. STATE  |  | B. COUNTY  |  |  |  |
| US Public Health Service Hospital<br>Wyman Pk. Drive & 31st St.   |  |  |  | Michigan  |  |  |  |  |  |
|   |  |  |  | C. CITY OR TOWN   |  | D. INSIDE CITY LIMITS?   |  |  |  |
|   |  |  |  | Detroit   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
|   |  |  |  | E. STREET AND NUMBER  |  |  |  |  |  |
|   |  |  |  | 241 Smith Street  |  |  |  |  |  |
| 5. SEX  |  | 6. RACE  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>            |  | 8. DATE OF BIRTH   |  | 9. AGE (In years last birthday)              |  |
| F   |  | N  |  | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>         |  | 8/1/02   |  | 67   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)   |  | 12. CITIZEN OF WHAT COUNTRY?   |  |  |  |
| Housewife   |  |  |  | Tenn.   |  | U.S.A.   |  |  |  |
| 13. FATHER'S NAME   |  |  |  | 14. MOTHER'S MAIDEN NAME  |  |  |  |  |  |
| Lee Gibson  |  |  |  | Mary Richard  |  |  |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |  |  |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |  |  |
| No  |  |  |  | ?   |  | Records- US PHS Hospital, Balto, Md.                                 |  |  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |  |  |  | CAUSE OF DEATH  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 436941180X  |  |  |  | Cerebrovascular Accident  |  |  |  | days   |  |
| 1. This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.   |  |  |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                   |  |  |  |  |  |
| ANTECEDENT CAUSES   |  |  |  | (B) DUE TO, OR AS A CONSEQUENCE OF:   |  |  |  |  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |  |  |  | (C)   |  |  |  |  |  |
| II  |  |  |  | Carcinoma of the cervix   |  |  |  | months                                       |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |  |  |   |  |  |  |  |  |
| 19A. DATE OF OPERATION  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
| 2   |  |  |  | yes   |  | yes  |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR?  |  | (If in Baltimore City, give exact location)                          |  |  |  |
| 21D. TIME OF INJURY (APPROX.)   |  | 21E. INJURY OCCURRED   |  | 21F. HOW DID INJURY OCCUR?  |  |  |  |  |  |
| (Month) (Day) (Year) (Hour)   |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |  |   |  |  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from Sept. 9 1969 to Nov. 1 1969 that (I) (we) last saw the deceased alive on Nov. 1 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |
| 23A. SIGNATURE  |  |  |  | 23B. DATE SIGNED  |  |  |  |  |  |
| Gary E. Feldman, M.D.   |  |  |  | 11/4/69   |  |  |  |  |  |
| 23C. PHYSICIAN'S NAME (Type)  |  |  |  | 23D. ADDRESS  |  |  |  |  |  |
| GARY E. FELDMAN, M.D.   |  |  |  | US PHS Hospital, Balto, Md.   |  |  |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |  | 24B. DATE  |  | 24C. NAME OF CEMETERY or CREMATORY  |  | 24D. LOCATION (City, town, or county) (State)                        |  |  |  |
| TRANSIT-BURIAL  |  | 11-8-69  |  | Detroit Memorial Park   |  | Detroit, McCome Co., Michigan  |  |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.   |  | 25B. NAME OF REGISTRAR   |  | 25C. FUNERAL DIRECTOR ADDRESS   |  |  |  |  |  |
| NOV 5 1969  |  | Robert E. Jones, Jr.   |  | Marshall W. Jones, Jr.  |  | 1735 Harford Ave.  |  |  |  |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

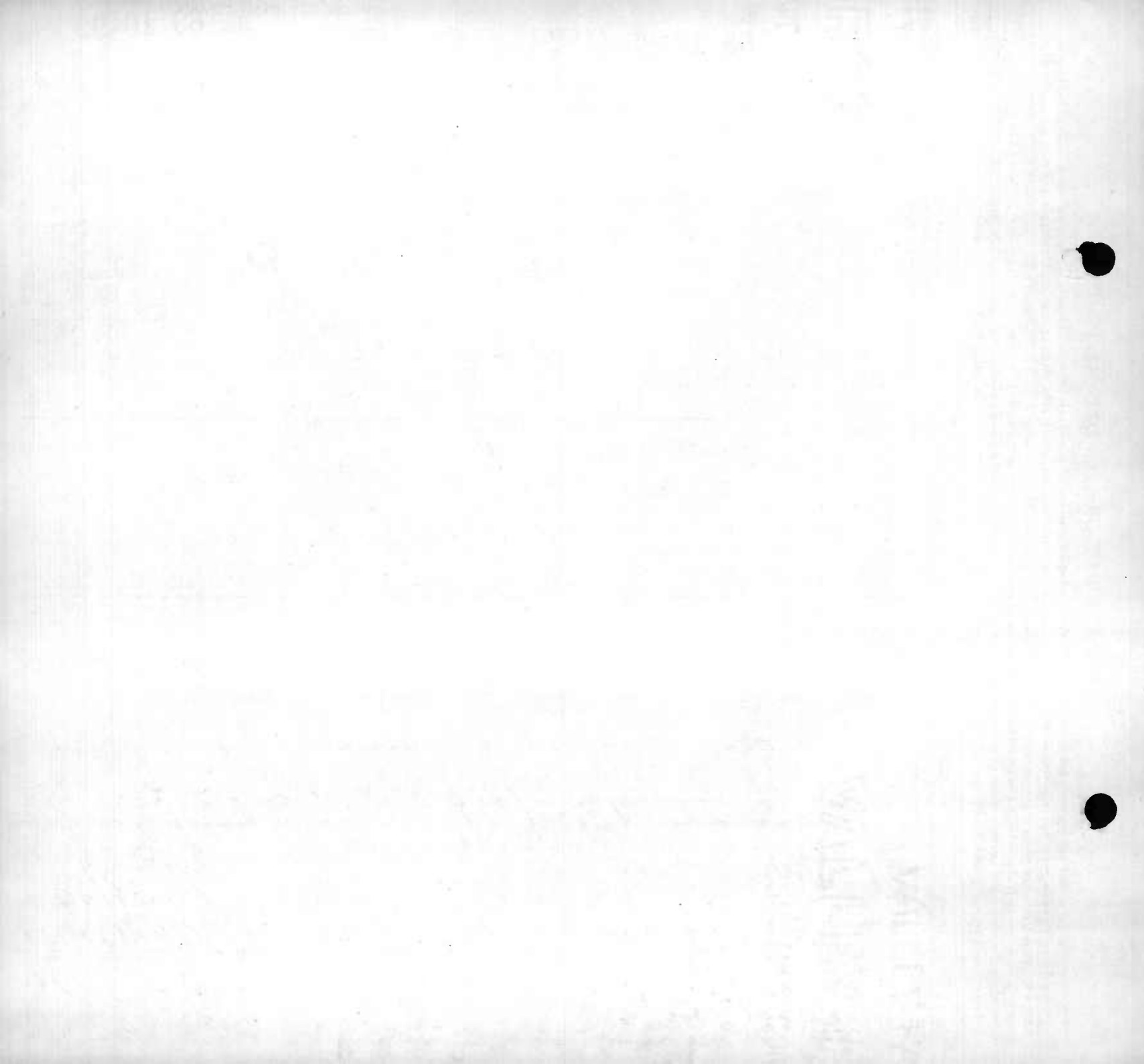
| BALTIMORE CITY HEALTH DEPARTMENT   |                      |   |                                 | REG. NO. <b>69 10898</b>  |   |
|--|----------------------|---|---------------------------------|---|---|
| <b>M-350 69 10898</b>  |                      |   |                                 | <b>CERTIFICATE OF DEATH</b>   |   |
| BIRTH NO.  |                      |   |                                 | DATE AND HOUR OF DEATH  |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>MOTON, Moses</b>   |                      |   |                                 | 10/30/69 <b>8:15 PM</b> M.  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                      |   |                                 | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>1607</b> |   |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>23 Veterans Administration Hospital<br/>3900 Loch Raven Boulevard<br/>Baltimore, Maryland 21218</b>  |                      |   |                                 | C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |   |
| E. STREET AND NUMBER <b>2808 Winchester Street</b>   |                      |   |                                 |   |   |
| 5. SEX <b>Male</b>   | 6. RACE <b>negro</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>8/24/94</b> | 9. AGE (in years last birthday) <b>75</b>   | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>   |                      | 10B. KIND OF BUSINESS OR INDUSTRY <b>lathe Operator</b>   |                                 | 11. BIRTHPLACE (State or foreign country) <b>Augusta Ga.</b>  |   |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |                      |   |                                 |   |   |
| 13. FATHER'S NAME <b>Moses Moton</b>   |                      |   |                                 | 14. MOTHER'S MAIDEN NAME <b>Anna Gant</b>   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 7/29/18-3/13/19</b>  |                      | 16. SOCIAL SECURITY NO. <b>210-10-1863</b>  |                                 | 17. INFORMANT ADDRESS <b>VA Hospital Records<br/>Baltimore, Maryland 21218</b>  |   |
| 18. <b>412.3 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Pulmonary infarction</b><br>CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>Arteriosclerotic heart disease</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>11 years</b><br>(C) _____<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. |                      |   |                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b>   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Chronic obstructive pulmonary disease</b>  |                      |   |                                 |   |   |
| 19A. DATE OF OPERATION   |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                 | 20A. AUTOPSY? (Yes or No) <b>NO</b>   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  |                      | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                                 | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 4th 1969</b> to <b>October 30th 1969</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>October 30th 1969</b> and that <input checked="" type="checkbox"/> (our) opinion on death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (did not) view the body after death.                              |                      |   |                                 |   |   |
| 23A. SIGNATURE <br>YOUNG E. CHUN, M.D.  |                      |   |                                 | 23B. DATE SIGNED <b>10/31/69</b>  |   |
| 23C. PHYSICIAN'S NAME (Type) <b>YOUNG E. CHUN, M.D.</b>  |                      |   |                                 | 23D. ADDRESS <b>3900 Loch Raven Blvd.,<br/>Baltimore, Maryland 21218</b>  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>   |                      | 24B. DATE <b>Nov 4/1969</b>   |                                 | 24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cem</b>  |   |
| 24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>  |                      |   |                                 |   |   |
| 25A. DATE RECD BY HEALTH DEPT. <b>NOV 5 1969</b>   |                      | 25B. NAME OF REGISTRAR <b>John E. Feltz, M.D.</b>   |                                 | 25C. FUNERAL DIRECTOR <b>Joseph B. Russ</b> ADDRESS <b>2222 W. North Ave.</b>   |   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                     |   |  |   |   |
|---|---------------------|---|--|---|---|
| S-663   |                     | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. 69 10899   |   |
| BIRTH NO. 69 10899  |                     | CERTIFICATE OF DEATH  |  |   |   |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Ida Vandiver Sherrard</i>   |                     | 2. DATE AND HOUR OF DEATH<br><i>Oct 28, 1969 12:30 A.M.</i>   |  |   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                     | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <i>Maryland</i> 8. COUNTY <i>1304</i>                     |  |   |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>2919 Parkwood Ave</i>  |                     | C. CITY OR TOWN<br><i>Baltimore</i>   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
|   |                     | E. STREET AND NUMBER<br><i>2919 Parkwood Ave</i>  |  |   |   |
| 5. SEX<br><i>F</i>  | 6. RACE<br><i>C</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><i>Mar 31, 1916</i>   | 9. AGE (In years last birthday) <i>53</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Householder</i>   |                     | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><i>Anderson S. Carolina</i>                      |   |
| 13. FATHER'S NAME<br><i>Cyrus Cunningham</i>  |                     | 14. MOTHER'S MAIDEN NAME<br><i>Laura Hawkins</i>  |  |   |   |
| 15. Was Deceased Ever in the U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |                     | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><i>Chilton Sherrard</i>  |   |
|   |                     |   |  | ADDRESS<br><i>3210 Annapolis Ln.</i>  |   |
| 18. <i>404 X I</i>  |                     | CAUSE OF DEATH  |  |   |   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  |                     | (A) IMMEDIATE CAUSE<br><i>RESPIRATORY FAILURE</i><br>DUE TO, OR AS A CONSEQUENCE OF:  |  |   |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                     | (B) <i>Hypertensive Cor Arteriosclerotic</i><br>DUE TO, OR AS A CONSEQUENCE OF:   |  |   |   |
|   |                     | (C) <i>Renal disease &amp; arteriosclerosis</i>   |  |   |   |
| II  |                     |   |  |   |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                     |   |  |   |   |
| 19A. DATE OF OPERATION  |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |   |
| 21D. TIME OF INJURY (APPROX.)   |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) (this hospital) attended the deceased from <i>10/27/69</i> 19 to <i>Oct 29 1969</i> that (I) (we) last saw the deceased alive on <i>10/27/69</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. |                     |   |  |   |   |
| 23A. SIGNATURE<br><i>S. BORDEN</i>  |                     | OEGREE  |  | 23B. DATE SIGNED<br><i>10/31/69</i>   |   |
| 23C. PHYSICIAN'S NAME (Type)<br><i>S. BORDEN</i>  |                     | 23D. ADDRESS<br><i>601 N. Morris St. Baltimore MD 21217</i>   |  |   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |                     | 24B. DATE<br><i>Nov. 1, 1969</i>  |  | 24C. NAME OF CEMETERY or CREMATORY<br><i>Westport Cemetery</i>                                |   |
| 24D. LOCATION<br><i>Westport (Baltimore) Md.</i>  |                     | 25A. DATE REC'D BY HEALTH DEPT.<br><i>NOV 5 1969</i>  |  |   |   |
| 25B. NAME OF REGISTRAR<br><i>Robert E. Taylor</i>   |                     | 25C. FUNERAL DIRECTOR<br><i>Joseph L. Kuss</i>  |  |   |   |
|   |                     | ADDRESS<br><i>2122 W. North Ave</i>   |  |   |   |

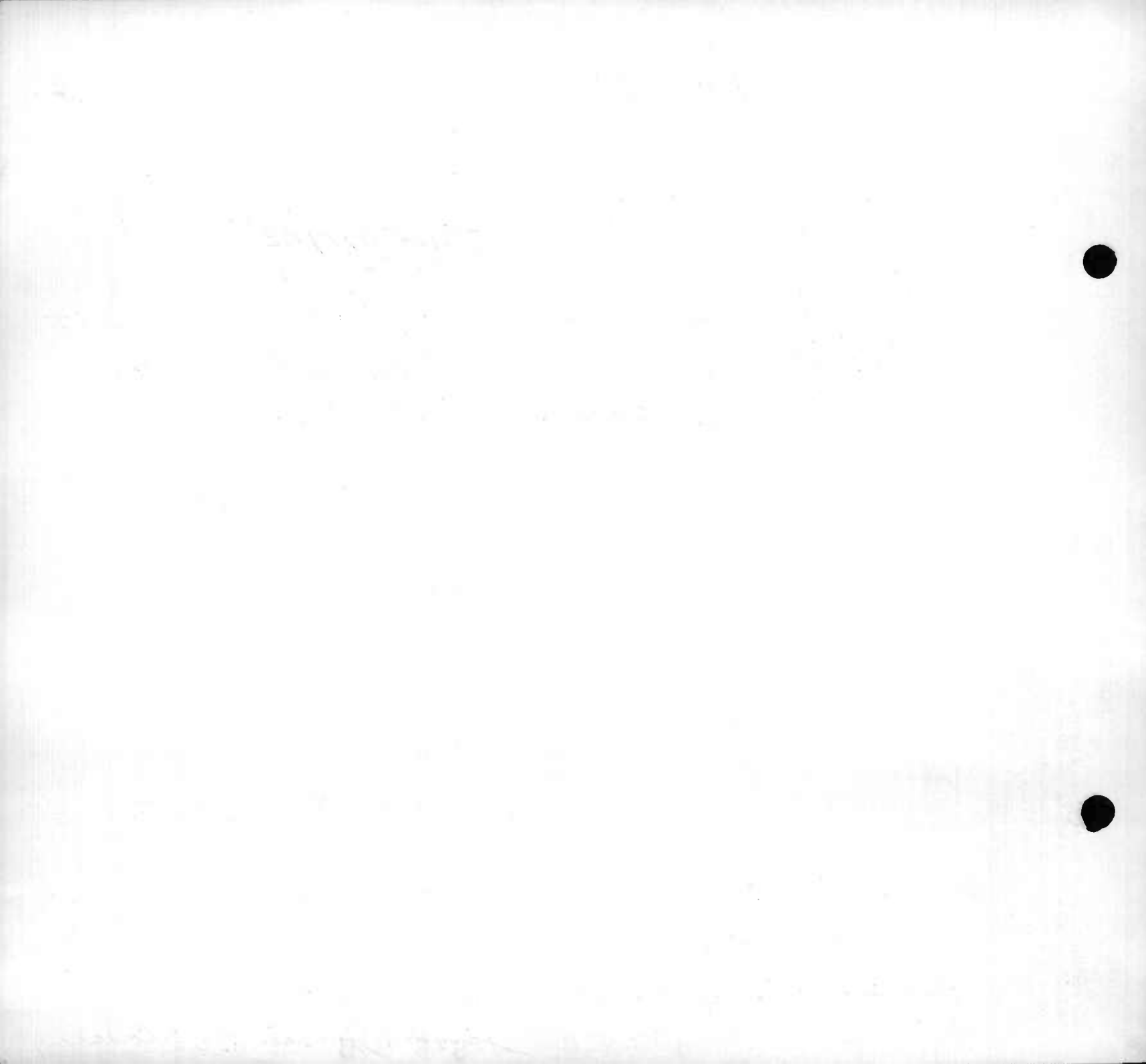




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| M-633   |  | 69 10900 |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. 69 10900   |  |
|---|--|----------|--|---|--|---|--|
| BIRTH NO.   |  |          |  | 1. NAME OF DECEASED<br>(Type or Print) <u>Leslie D. MEREDITH</u>  |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  |          |  | 2. DATE AND HOUR OF DEATH<br><u>11-3-69</u> <u>4:47</u> M.  |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>37 MERCY Hospital</u>  |  |          |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>MD</u> B. COUNTY <u>2608</u>   |  |   |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |  |          |  | C. CITY OR TOWN<br><u>BALTO</u>   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 5. SEX <u>M</u> 6. RACE <u>W</u>  |  |          |  | E. STREET AND NUMBER<br><u>3412 E. PRATT ST</u>   |  |   |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |          |  | 8. DATE OF BIRTH <u>10-24-69</u> 9. AGE <u>11</u> 10. YEARS <u>6</u>  |  |   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>GAURD</u>   |  |          |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>MONUMENTAL LIFE</u>   |  |   |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>MARYLAND</u>  |  |          |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A</u>  |  |   |  |
| 13. FATHER'S NAME<br><u>Philip</u>  |  |          |  | 14. MOTHER'S MAIDEN NAME<br><u>ARINITHA UNK</u>   |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>   |  |          |  | 16. SOCIAL SECURITY NO.<br><u>220-01-2592</u>   |  | 17. INFORMANT<br><u>Hospit Records</u>  |  |
| 18. <u>412.41</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first. |  |          |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><u>Sub acute bacterial endocarditis</u><br>(B) <u>ASC: V.D.</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <u>Anemia</u> |  |   |  |
| 19. DATE OF OPERATION<br><u>0</u>   |  |          |  | 20. AUTOPSY? (Yes or No)<br><u>No</u>   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><u>No</u>  |  |          |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |  |          |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10-24-1969</u> to <u>11-3-1969</u> that (I) (we) last saw the deceased alive on <u>11-3-1969</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                        |  |          |  |   |  |   |  |
| 23A. SIGNATURE<br><u>Abdolhamid Ghiladi</u>   |  |          |  | 23B. DATE SIGNED<br><u>11-3-69</u>  |  | 23C. PHYSICIAN'S NAME (Type)<br><u>Abdolhamid Ghiladi</u>                                     |  |
| 23D. ADDRESS<br><u>Mercy Hosp. Balto Md 2</u>   |  |          |  | 23E. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>   |  | 23F. DEGREE   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |  |          |  | 24B. DATE<br><u>Nov 6, 1969</u>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><u>OAKLAND Cem</u>                                      |  |
| 24D. LOCATION<br><u>BALTO</u>   |  |          |  | 24E. (City, town, or county)  |  | 24F. (State)<br><u>MD</u>   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 5 1969</u>  |  |          |  | 25B. NAME OF REGISTRAR<br><u>John E. Taylor, MD</u>   |  | 25C. FUNERAL DIRECTOR<br><u>Joseph J. Gorman</u>  |  |
| 25D. ADDRESS<br><u>2635 Conowingo</u>   |  |          |  | 25E. (City, town, or county)  |  | 25F. (State)  |  |



# FUNERAL DIRECTOR: IMPORTANT

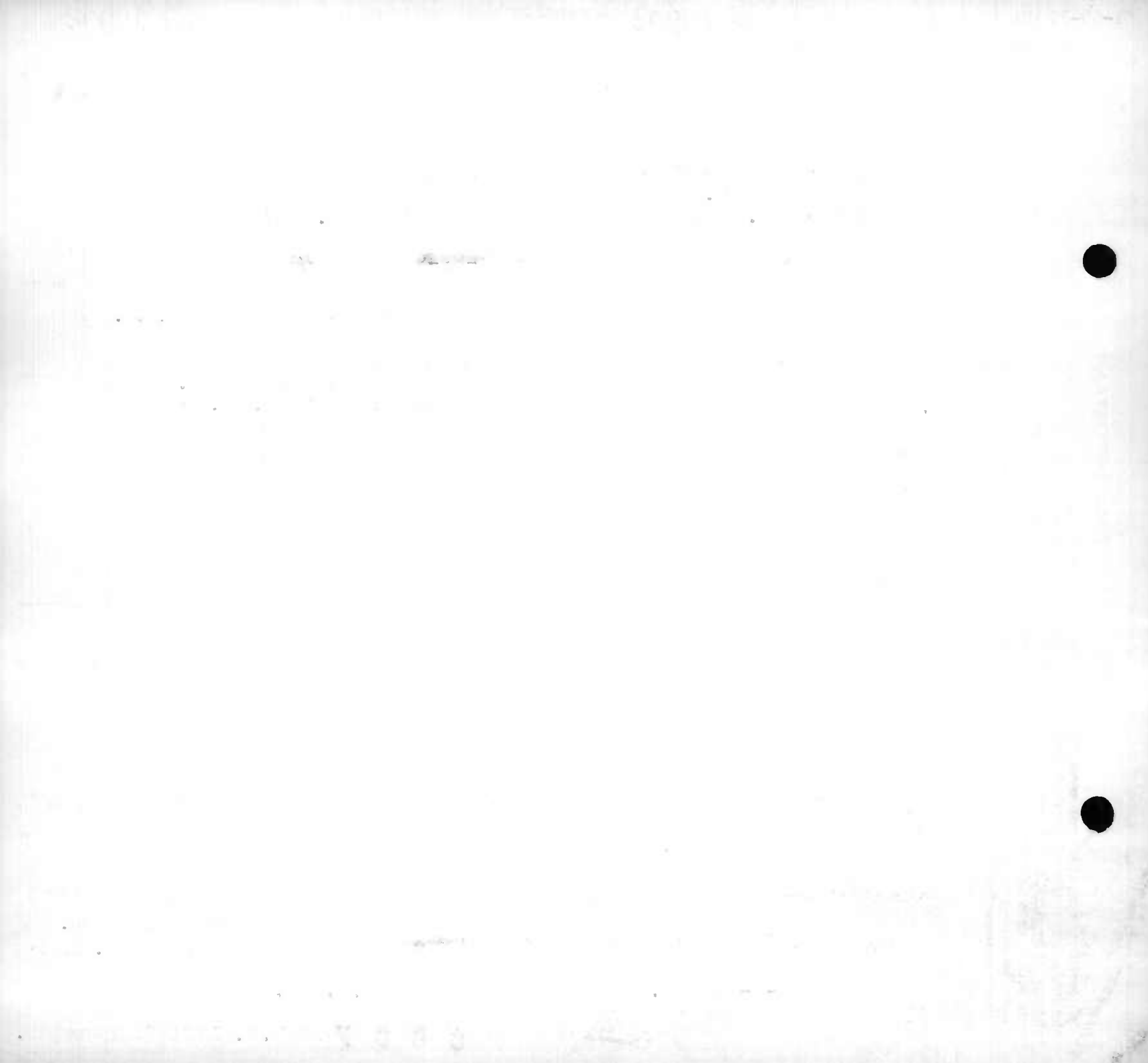
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| L-000  |  | 69 10901 |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. 69 10901  |  |
|--|--|----------|--|---|--|--|--|
| BIRTH NO.  |  |          |  | 1. NAME OF DECEASED<br>(Type or Print) <i>Robert E. Lee</i>   |  |  |  |
| 2. DATE AND HOUR OF DEATH<br><i>11-2-69</i>  |  |          |  | 12. <i>05</i> P.M.  |  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |          |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY <i>2802</i>   |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><i>Sinai Hospital of Baltimore</i>  |  |          |  | C. CITY OR TOWN<br><i>Baltimore</i>   |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 5. SEX <i>M</i> 6. RACE <i>N</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |          |  | 8. DATE OF BIRTH<br><i>3-1-20</i>   |  | 9. AGE (In years last birthday) <i>49</i>  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Truck Mechanic</i>   |  |          |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><i>Maryland, Balto.</i>               |  |
| 13. FATHER'S NAME<br><i>Bernard Lee</i>  |  |          |  | 14. MOTHER'S MAIDEN NAME<br><i>Alice Lee</i>  |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>NO.</i>   |  |          |  | 16. SOCIAL SECURITY NO.<br><i>213-12-6832</i>   |  | 17. INFORMANT<br><i>Mrs. Grace Lee</i>   |  |
| 18. <i>450 X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |  |          |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br><i>Pulmonary Thrombosis and lung Infarction</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><i>?</i><br>(C) DUE TO, OR AS A CONSEQUENCE OF:<br><i>?</i> |  |  |  |
| 19A. DATE OF OPERATION<br><i>0</i>   |  |          |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  |          |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)           |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  |          |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>10-21</i> 19 <i>65</i> to <i>11-2</i> 19 <i>69</i> that (I) (we) last saw the deceased alive on <i>11-2</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |  |          |  |   |  |  |  |
| 23A. SIGNATURE<br><i>Hatten M.D.</i>   |  |          |  | 23B. DATE SIGNED<br><i>11-2-69</i>  |  | 23C. PHYSICIAN'S NAME (Type)<br><i>CARLOS S. VALLEJOS M.D.</i>                     |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |  |          |  | 24B. DATE<br><i>11/6/69</i>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Arbutus Mem. Park</i>                     |  |
| 24D. LOCATION (City, town, or county) (State)<br><i>Baltimore, Maryland</i>  |  |          |  | 25A. DATE REC'D BY HEALTH DEPT.<br><i>NOV 5 1969</i>  |  |  |  |
| 25B. NAME OF REGISTRAR<br><i>Robert E. Taylor M.D.</i>   |  |          |  | 25C. FUNERAL DIRECTOR<br><i>Mothers &amp; Dyett F.H.</i>  |  |  |  |
| 25D. ADDRESS<br><i>1701 Laurens St</i>   |  |          |  |   |  |  |  |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO.   |                  | BALTIMORE CITY HEALTH DEPARTMENT   |   | REG. NO.   |   |
|---|------------------|--|---|--|---|
| 4-400   |                  | 69 10902   |   | 69 10902   |   |
| CERTIFICATE OF DEATH  |                  |  |   |  |   |
| 1. NAME OF DECEASED<br>(Type or Print)<br>NELLIE MATTISON HILL (Tellington)   |                  |  | 2. DATE AND HOUR OF DEATH<br>Nov 3 1969 12:5 PM M.  |  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>31 Baltimore City Hospitals<br>4940 Eastern Ave.<br>Baltimore Md. 21224  |                  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland<br>B. COUNTY Baltimore<br>C. CITY OR TOWN<br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER<br>2827 Riggs Ave. 21216 007 |  |   |
| 5. SEX<br>Female  | 6. RACE<br>Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br>4-27-97   | 9. AGE (In years last birthday)<br>72                                    | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife  |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>Home  | 11. BIRTHPLACE (State or foreign country)<br>SC, Anderson   |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                      |
| 13. FATHER'S NAME<br>Jim Madison  |                  |  | 14. MOTHER'S MAIDEN NAME<br>Sarah Arnold  |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No.   |                  | 16. SOCIAL SECURITY NO.  | 17. INFORMANT<br>4940 Eastern Ave. ADDRESS<br>BCH Records; Baltimore, Md. 21224   |  |   |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>cerebrovascular accident<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |                  |  |   |  |   |
| 19A. DATE OF OPERATION<br>0   |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No)<br>No  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)  |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |   | 21F. HOW DID INJURY OCCUR  |   |
| 22. I certify that (1) (this hospital) attended the deceased from Oct 21 1969 to Nov 3 1969 that (1) (we) last saw the deceased alive on Nov 3 1969 and that (1) (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.  |                  |  |   |  |   |
| 23A. SIGNATURE<br>Matthew Pollack MD  |                  |  | 23B. DATE SIGNED<br>Nov 3 1969  |  | 23C. PHYSICIAN'S NAME (Type)<br>MATTHEW POLLACK MD          |
| 23D. ADDRESS<br>Baltimore City Hospitals Baltimore Md. 21224  |                  |  | 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |  |   |
| 24B. DATE<br>11-8-69  |                  | 24C. NAME of CEMETERY or CREMATORY<br>Mt. Calvary Cemetery   |   | 24D. LOCATION (City, town, or county) (State)<br>A.A. Co., Maryland      |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 5 1969   |                  | 25B. NAME OF REGISTRAR<br>Robert E. Taylor JR.   |   | 25C. FUNERAL DIRECTOR<br>MORTON B. DYE F.H. 1701 Laurens St.             |   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| B-623 69 10903 BALTIMORE CITY HEALTH DEPARTMENT  |  |                         |  |   |  |  |  |  |   | REG. NO. 69 10903   |  |
|--|--|-------------------------|--|---|--|--|--|--|---|---|--|
| BIRTH NO.  |  |                         |  |   |  |  |  |  |   |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>GORDON BROODEN</b>   |  |                         |  |   |  | 2. DATE AND HOUR OF DEATH<br><b>11/3/69 5<sup>28</sup> A M.</b>  |  |  |   |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |                         |  |   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>BALT</b> |  |  |   |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>UNIV. MARYLAND HOSP</b><br><b>38 BALT. MD.</b>  |  |                         |  |   |  | C. CITY OR TOWN<br><b>BALT</b>   |  |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |  |                         |  |   |  | E. STREET AND NUMBER<br><b>122 N. CARLTON ST.</b>  |  |  |   |   |  |
| 5. SEX<br><b>M</b>   |  | 6. RACE<br><b>BLACK</b> |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>4/22/32</b>   |  | 9. AGE (in years last birthday)<br><b>37</b>                                     |   | 10. Under 1 Yr. Months Days<br>11. Under 24 Hrs. Hours Min.                 |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>unemployed</b>   |  |                         |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  |  |  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND, Balt.</b>              |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                  |  |
| 13. FATHER'S NAME<br><b>WILLIAM</b>  |  |                         |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>ELLA Simms</b>  |  |  |   |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>YES ARMY</b>  |  |                         |  | 16. SOCIAL SECURITY NO.<br><b>218-26-5805</b>   |  | 17. INFORMANT<br><b>MOTHER</b>   |  |  | ADDRESS<br><b>SAME</b>  |   |  |
| 18. <b>571.9 I</b> CAUSE OF DEATH  |  |                         |  |   |  |  |  |  |   |   |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                |  |                         |  |   |  |  |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>CIRRHOSIS LIVER</b> |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 yrs</b>                |  |
|  |  |                         |  |   |  |  |  | (B) <b>ACUTE RENAL FAILURE</b>   |   | DUE TO, OR AS A CONSEQUENCE OF:<br><b>1 WEEK</b>                            |  |
|  |  |                         |  |   |  |  |  | (C)  |   |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>① Lung Pneumonia</b>  |  |                         |  |   |  |  |  |  |   |   |  |
| 19A. DATE OF OPERATION<br><b>0</b>   |  |                         |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>   |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?        |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |  |                         |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)         |   |   |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |  |                         |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  |  |  | 21F. HOW DID INJURY OCCUR?   |   |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10/24</b> 19 <b>69</b> to <b>11/3</b> 19 <b>69</b> that (I) (we) last saw the deceased alive on <b>11/2</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                         |  |   |  |  |  |  |   |   |  |
| 23A. SIGNATURE<br><b>Howard Wallach, M.D.</b>  |  |                         |  |   |  |  |  | 23B. DATE SIGNED<br><b>11/3/69</b>   |   | 23C. PHYSICIAN'S NAME (Type)<br><b>HOWARD WALLACH, M.D.</b>                 |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |                         |  | 24B. DATE<br><b>11/8/69</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Ht Auburn Cem.</b>  |  |  |   | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 5 1969</b>   |  |                         |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher, M.D.</b>   |  |  |  | 25C. FUNERAL DIRECTOR<br><b>Marlene Byett F.H.</b>                               |   |   |  |
|  |  |                         |  |   |  |  |  | ADDRESS<br><b>1701 Laurens St.</b>   |   |   |  |





**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                     |  |                                     |   |  |
|---|---------------------|--|-------------------------------------|---|--|
| W-300 69 10904  |                     | BALTIMORE CITY HEALTH DEPARTMENT<br><b>CERTIFICATE OF DEATH</b>  |                                     | REG. NO. 69 10904   |  |
| BIRTH NO.   |                     | 1. NAME OF DECEASED<br>(Type or Print) <b>WILLIAM A. WHITE</b>   |                                     | 2. DATE AND HOUR OF DEATH<br><b>Nov. 1, 1969 1:35 P.M.</b>                                    |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                     | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>BALT.</b>  |                                     | C. CITY OR TOWN <b>BALT.</b>  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>SINAI HOSPITAL</b>   |                     | E. STREET AND NUMBER<br><b>3745 REISTERS TOWN RD</b>   |                                     | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 5. SEX<br><b>M</b>  | 6. RACE<br><b>N</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    | 8. DATE OF BIRTH<br><b>12/26/42</b> | 9. AGE (In years last birthday)<br><b>26</b>  | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Upholstering factory</b>  |                     | 10B. KIND OF BUSINESS OR INDUSTRY  |                                     | 11. BIRTHPLACE (State or foreign country)<br><b>Balt. Maryland</b>                            |  |
| 13. FATHER'S NAME<br><b>James R. White</b>  |                     | 14. MOTHER'S MAIDEN NAME<br><b>Mary Lee</b>  |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes</b>  |                     | 16. SOCIAL SECURITY NO.<br><b>214-46-8387</b>  |                                     | 17. INFORMANT<br><b>Mrs. Marylee White</b>  |  |
| 18. <b>371.0 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                |                     | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>Hepatic Coma</b><br>(B) <b>Alcoholic Cirrhosis</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____ |                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 weeks</b>                                |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>Renal Tubular acidosis</b>   |                     |  |                                     |   |  |
| 19A. DATE OF OPERATION<br><b>0</b>  |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>_____  |                                     | 20A. AUTOPSY? (Yes or No)<br><b>No</b>  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)   |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                                     | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                                     | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from <b>8/23/69</b> 19 to <b>11/1/69</b> 19 that <u>(I)</u> (we) lost saw the deceased alive on <b>Nov. 1</b> 19 <b>69</b> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> (We) (did) (did not) view the body after death. |                     |  |                                     |   |  |
| 23A. SIGNATURE<br><b>Victor Borden M.D.</b>   |                     | 23B. DATE SIGNED<br><b>Nov. 4, 1969</b>  |                                     | 23C. PHYSICIAN'S NAME (Type)<br><b>VICTOR BORDEN MD.</b>                                      |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                     | 24B. DATE<br><b>11/6/69</b>  |                                     | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Balt. Nat'l Cem.</b>                                 |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>   |                     | 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 5 1969</b>   |                                     | 25B. NAME OF REGISTRAR<br><b>Robert E. Barber, M.D.</b>                                       |  |
| 25C. FUNERAL DIRECTOR<br><b>Morton J. Dgett F.H.</b>  |                     | 25D. ADDRESS<br><b>1701 Laurens St.</b>  |                                     |   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                  |   |   | REG. NO. 69 10905  |   |
|---|------------------|---|---|--|---|
| BIRTH NO. 8-230   |                  | 69 10905  |   | CERTIFICATE OF DEATH   |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>SAMUEL H. BACON</b>   |                  |   | 2. DATE AND HOUR OF DEATH<br><b>11/3/69 12:35 P. M.</b>   |  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                  |   | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)   |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>48 MARYLAND GENERAL HOSPITAL</b>   |                  |   | A. STATE <b>MARYLAND</b><br>B. COUNTY <b>1301</b>   |  |   |
| C. CITY OR TOWN <b>BALTIMORE</b>  |                  |   | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |
| E. STREET AND NUMBER <b>2401 Eutan Place</b>  |                  |   |   |  |   |
| 5. SEX <b>M</b>   | 6. RACE <b>N</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>4/6/1918</b>  | 9. AGE (In years last birthday) <b>51</b>                                | If Under 1 Yr. Months Days<br>If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CONSTRUCTION</b>   |                  |   | 11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>   |  |   |
| 10B. KIND OF BUSINESS OR INDUSTRY   |                  |   | 12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>   |  |   |
| 13. FATHER'S NAME <b>Andrew J. Bacon</b>  |                  |   | 14. MOTHER'S MAIDEN NAME <b>Ada Marable</b>   |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO.</b>   |                  |   | 16. SOCIAL SECURITY NO. <b>226-34-5548</b>  |  |   |
| 17. INFORMANT <b>MARY WALTON</b>  |                  |   | ADDRESS <b>339 WADSWORTH RD 21218</b>   |  |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>162.1 I</b>  |                  |   | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <b>CANCER OF LUNG</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <b>(TERMINAL)</b><br>(C) <b>?</b> |  |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>JOHNS HOPKINS HOSP.</b>  |  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                  |   |   |  |   |
| 19A. DATE OF OPERATION <b>0</b>   |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No) <b>NO</b>                                      |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |   | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>11/3</b> 19 <b>69</b> to <b>11/3</b> 19 <b>69</b> that (I) (we) last saw the deceased alive on <b>11/3</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                  |   |   |  |   |
| 23A. SIGNATURE <b>Artemio M. Cuevas MD</b>  |                  |   |   | 23B. DATE SIGNED <b>11/3/69</b>  |   |
| 23C. PHYSICIAN'S NAME (Type) <b>ARTEMIO M. CUEVAS, MD</b>   |                  |   |   | 23D. ADDRESS <b>Maryland Gen. Hospital</b>                               |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |                  | 24B. DATE <b>11/10/69</b>   |   | 24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Mitchell Ch. Cem.</b>          |   |
| 24D. LOCATION (City, town, or county) <b>Lunenburg Co.</b>  |                  | (State) <b>Virginia</b>   |   |  |   |
| 25A. DATE REC'D BY HEALTH DEPT. <b>NOV 5 1969</b>   |                  | 25B. NAME OF REGISTRAR <b>Robert E. Tabor, M.D.</b>   |   | 25C. FUNERAL DIRECTOR <b>MORTON D. DEH F.H.</b>                          |   |
| ADDRESS <b>1701 Laurens St.</b>   |                  |   |   |  |   |



1  
G-624 69 10906 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 69 10906

|  |                         |   |  |  |  |
|--|-------------------------|---|--|--|--|
| BIRTH NO.  |                         | 1. NAME OF DECEASED<br>(Type or Print) <b>THOMAS GRIZEL GRIZZEL</b>   |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> M.  |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>33 JOHNS HOPKINS HOSPITAL</b>   |                         | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>October 31, 1969 5:56 P.M.</b>   |  | 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Calvert</b> C. CITY OR TOWN <b>Lusby</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 6. SEX<br><b>Male</b>  | 7. RACE<br><b>White</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | E. STREET AND NUMBER<br><b>Box 612, Coster Road</b>  |  |
| 9. DATE OF BIRTH<br><b>9/23/1885</b>   |                         | 10. AGE (In years last birthday) <b>84</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Dante Va.</b>  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |                         | 13. FATHER'S NAME<br><b>Henry Grizzel</b>   |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Carpenter</b>   |  |
| 15. MOTHER'S MAIDEN NAME<br><b>Larina Skanis</b>   |                         | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>  |  | 17. SOCIAL SECURITY NO.<br><b>188-03-1411</b>  |  |
| 18. INFORMANT<br><b>Henry Grizzel</b>  |                         | ADDRESS<br><b>East Berlin, Pa.</b>  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Pulmonary Embolism</b>  |                         | CAUSE OF DEATH<br><b>Pulmonary Embolism</b>   |  |  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Craniocerebral Injuries</b>   |                         | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:  |  |  |  |
| (B) <b>Craniocerebral Injuries</b><br>DUE TO, OR AS A CONSEQUENCE OF:  |                         |   |  |  |  |
| (C) _____  |                         |   |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                         |   |  |  |  |
| 20A. DATE OF OPERATION<br><b>2</b>   |                         | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 21. AUTOPSY? (Yes or No)<br><b>yes</b>   |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.<br><input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING   |                         | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Street</b>   |  | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>St. Rte. 5, 1 1/2 Mile North of State Rte. 6, Charlotte Hall</b>  |  |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)<br><b>Oct. 15, 1969 1:10P.</b>   |                         | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | 22F. HOW DID INJURY OCCUR?<br><b>Driver in auto-auto collision</b>   |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED<br><b>11/1/69</b> |                         |   |  |  |  |
| ACTUAL SIGNATURE<br><b>Ronald N. Kornblum</b><br>EXAMINER'S NAME (Type)  |                         | M.D.<br><b>Ronald N. Kornblum, M.D.</b>   |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 24B. DATE<br><b>11-4-1969</b>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Mt. Olivet Cemetery</b>   |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Hanover, York Co. Pa.</b>  |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 5 1969</b>  |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Tabor, M.D.</b>   |  |
| 25C. FUNERAL DIRECTOR<br><b>Tyson Eline - Hampstead, Md.</b>   |                         | ADDRESS   |  |  |  |

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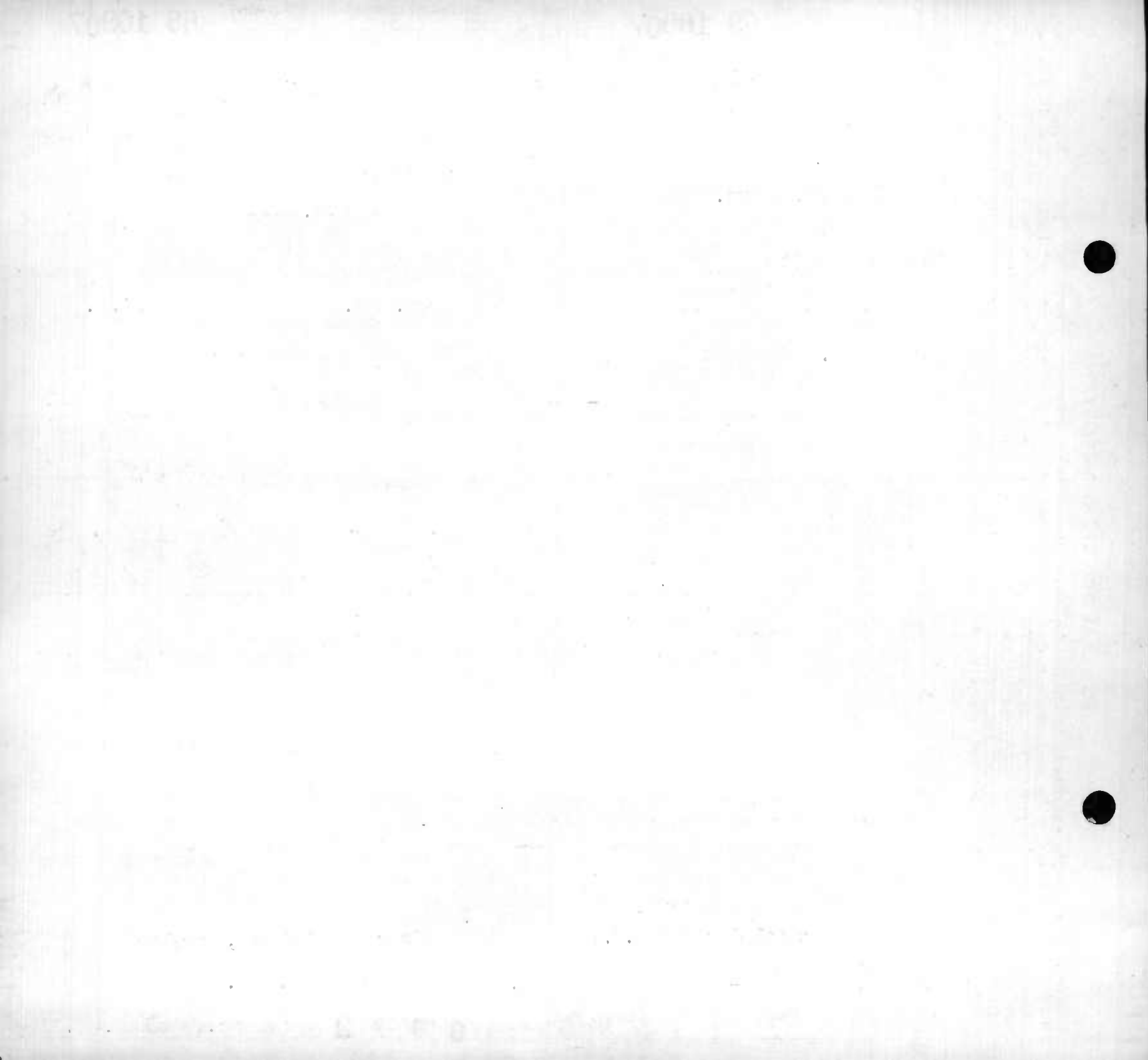
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |                  |   |   | REG. NO. <b>69 10907</b>   |   |
|--|------------------|---|---|--|---|
| 69 10907   |                  | CERTIFICATE OF DEATH  |   |  |   |
| BIRTH NO.  |                  | Victoria  |   | 2. DATE AND HOUR OF DEATH  |   |
| 1. NAME OF DECEASED<br>(Type or Print)   |                  | FRANCES JEDLANEK  |   | November 4, 1969   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)   |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><br>00 5202 Nuth Ave.  |                  |   | A. STATE<br>Maryland  |  |   |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |                  |   | C. CITY OR TOWN<br>Baltimore  |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|  |                  |   | E. STREET AND NUMBER<br>5205 Nuth Ave.  |  |   |
| 5. SEX<br>Female   | 6. RACE<br>White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>12-29-1889  | 9. AGE (In years lost birthday)<br>79                                    | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife   |                  | 10B. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country)<br>Balto. Md.                  |   |
| 13. FATHER'S NAME<br>George W. Dziennik  |                  | 14. MOTHER'S MAIDEN NAME<br>Josephine Buczkowski  |   | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No   |                  | 16. SOCIAL SECURITY NO.<br>212-52-7363  |   | 17. INFORMANT<br>Charles Jedlanek 5202 Nuth Ave 21206                    |   |
| 18. <b>412.2 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. |                  |   | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>Pulmonary Edema<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) Cardio-Vascular Hypertensive Disease<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) Atherosclerosis |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 minutes<br>12 yrs.<br>12 yrs.              |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |                  |   |   |  |   |
| 19A. DATE OF OPERATION<br>2  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |   | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (the hospital) attended the deceased from July 1960 to Nov. 4, 1969, that (I) lost the deceased alive on Oct. 30, 1969, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (didn't) view the body after death.   |                  |   |   |  |   |
| 23A. SIGNATURE<br>Michael J. Dausch, M.D.  |                  |   |   | 23B. DATE SIGNED<br>11/4/69  |   |
| 23C. PHYSICIAN'S NAME (Type)<br>Michael J Dausch M.D.  |                  |   |   | 23D. ADDRESS<br>4636 Belair Rd Baltimore, Maryland                       |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial   |                  | 24B. DATE<br>11-8-69  |   | 24C. NAME OF CEMETERY or CREMATORY<br>Parkwood Cem.                      |   |
|  |                  |   |   | 24D. LOCATION (City, town, or county) (State)<br>Balto. Md.              |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 6 1969  |                  | 25B. NAME OF REGISTRAR<br>Robert E. Sabers, M.D.  |   | 25C. FUNERAL DIRECTOR<br>Leonard J Ruck Inc., Balto. Md. 21214           |   |



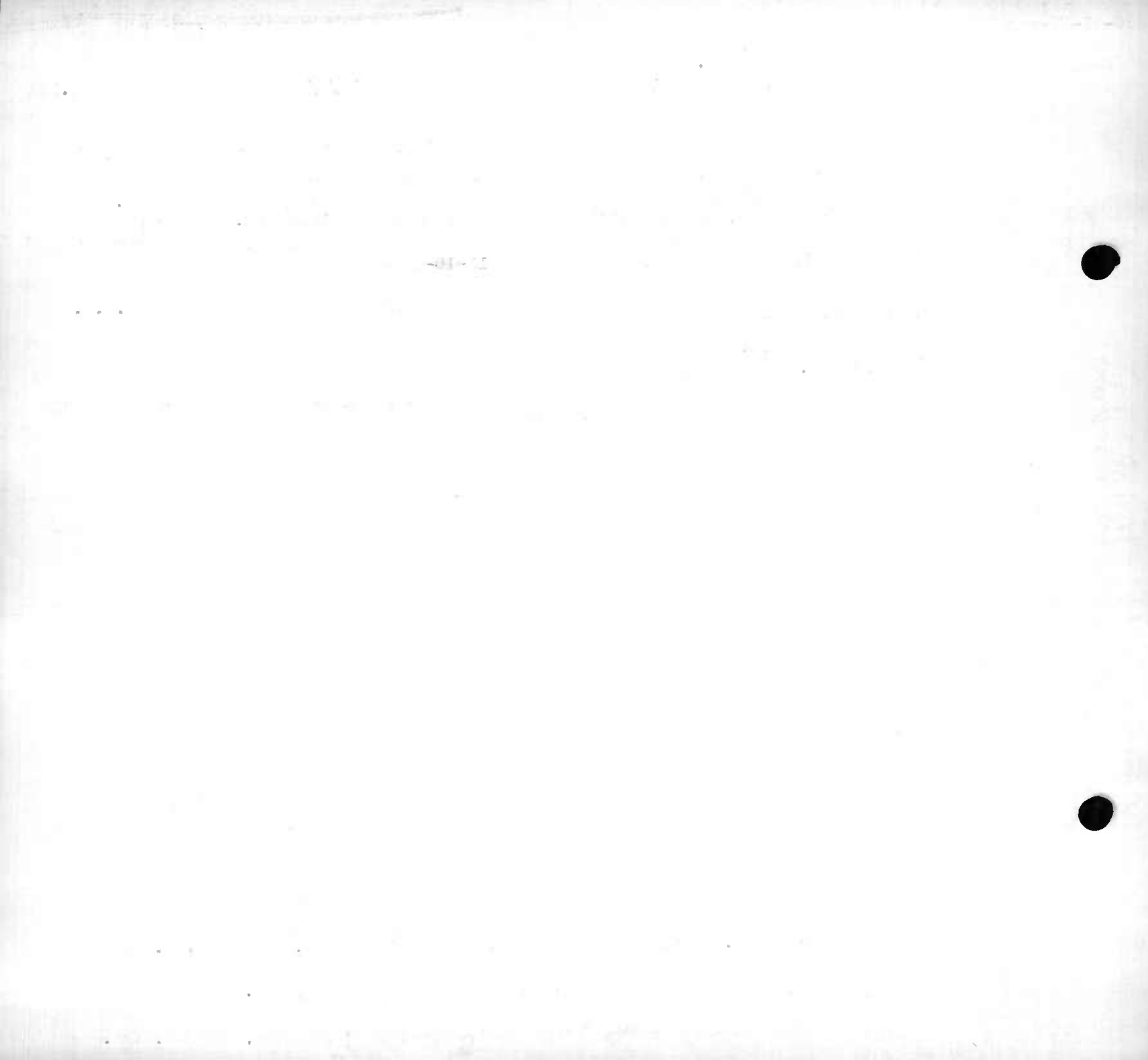


W-452

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                  |  |                                |  |  |
|--|------------------|--|--------------------------------|--|--|
| BIRTH NO.<br>69 10908  |                  | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH   |                                | REG. NO. 69 10908  |  |
| 1. NAME OF DECEASED<br>(Type or Print)<br>James Williams   |                  | 2. DATE AND HOUR OF DEATH<br>11/4/1969 4:15A.M.  |                                |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>BALTIMORE CITY HOSPITALS<br>4940 Eastern Avenue<br>Baltimore, Maryland 21224   |                  | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>A. STATE Maryland B. COUNTY Virginia<br>C. CITY OR TOWN Baltimore<br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER 2117 Ellison Ave.<br>309X3XXXPPXX1XXXXX<br>21230 |                                |  |  |
| 5. SEX<br>Male   | 6. RACE<br>White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>   | 8. DATE OF BIRTH<br>12-18-1914 | 9. AGE (In years last birthday)<br>54  | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Cement Finisher   |                  | 10B. KIND OF BUSINESS OR INDUSTRY  |                                | 11. BIRTHPLACE (State or foreign country)<br>Virginia  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |                  | 13. FATHER'S NAME<br>C.H.W.<br>Charles H. Williams   |                                |  |  |
| 14. MOTHER'S MAIDEN NAME<br>Nora Strouth   |                  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No   |                                |  |  |
| 16. SOCIAL SECURITY NO.<br>223-12-1233   |                  | 17. INFORMANT ADDRESS<br>Records: BCH-4940 Eastern Avenue 21224  |                                |  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>Cardiac Arrest<br>Probable Pulmonary Emboli<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____  |                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>25 minutes<br>34 hours<br>25 minutes<br>36 hours |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br>tuberculosis, atrial flutter/fibrillation  |                  |  |                                |  |  |
| 19A. DATE OF OPERATION   |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                | 20A. AUTOPSY? (Yes or No)<br>YES   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                                | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                         |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                                | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (X) (this hospital) attended the deceased from 9/28/69 19 to 11/4/69 19 that (X) (we) last saw the deceased alive on 11/4/69 19 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.                           |                  |  |                                |  |  |
| 23A. SIGNATURE<br>Jaime F. Casellas M.D.   |                  | 23B. DATE SIGNED<br>4 Nov '69  |                                | 23C. PHYSICIAN'S NAME (Type)<br>Jaime F. Casellas  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial   |                  | 24B. DATE<br>11-7-69   |                                | 24C. NAME OF CEMETERY OR CREMATORY<br>Sherwood Memorial Park                                     |  |
| 24D. LOCATION (City, town, or county) (State)<br>Salem, Va.  |                  | 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 6 1969  |                                |  |  |
| 25B. NAME OF REGISTRAR<br>Robert E. Taylor, R.D.   |                  | 25C. FUNERAL DIRECTOR<br>Leonard J. Buck Inc. Balto. Md.   |                                |  |  |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |               |  |                           | CERTIFICATE OF DEATH  |   | REG. NO. 69 10909   |  |
|---|---------------|--|---------------------------|---|---|---|--|
| BIRTH NO. 69 10909  |               | 1. NAME OF DECEASED (Type or Print) MEYER, DORA  |                           | 2. DATE AND HOUR OF DEATH NOVEMBER 3, 1969 6:30A M.   |   |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |               | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO CO                               |                           | 5. CITY OR TOWN BALTIMORE   |   | 6. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTIMORE, MARYLAND 21229  |               | E. STREET AND NUMBER 18 PARADISE AVE. 53-00  |                           |   |   |   |  |
| 5. SEX FEMALE   | 6. RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 03 05 78 | 9. AGE (In years last birthday) 91  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife   |               | 10B. KIND OF BUSINESS OR INDUSTRY  |                           | 11. BIRTHPLACE (State or foreign country) GERMANY   |   | 12. CITIZEN OF WHAT COUNTRY? U.S.A.   |  |
| 13. FATHER'S NAME JOHAN BACH  |               | 14. MOTHER'S MAIDEN NAME AMELIA (HELLER)   |                           | 17. INFORMANT AYES.-BALTIMORE, MD. ADDRESS 21229 ST. AGNES HOSP. RECORDS-CATON & WILKENS  |   |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) NO  |               | 16. SOCIAL SECURITY NO. 219-12-5038D   |                           |   |   |   |  |
| 18. 436.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)   |               | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebro Vascular Acc.  |                           |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                    |  |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |               | (B) Atherosclerosis, generalized DUE TO, OR AS A CONSEQUENCE OF:   |                           |   |   |   |  |
| (C) _____   |               |  |                           |   |   |   |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |               |  |                           |   |   |   |  |
| 19A. DATE OF OPERATION 0  |               | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                           | 20A. AUTOPSY? (Yes or No) NO  |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?            |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>  |               | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                           | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |   |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |               | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                           | 21F. HOW DID INJURY OCCUR?  |   |   |  |
| 22. I certify that (X) (this hospital) attended the deceased from NOVEMBER 3 19 69 to NOVEMBER 4 19 69 that (X) (we) last saw the deceased alive on NOVEMBER 4 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. |               | 23A. SIGNATURE Carlos M. Orbegoso. DEGREE  |                           | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |   | 23B. DATE SIGNED 11-4-69  |  |
| 23C. PHYSICIAN'S NAME (Type) CARLOS ORBEGOSO  |               | 23D. ADDRESS M.D. CATON & WILKENS AVES.-BALTO., MD. 21229  |                           |   |   |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial   |               | 24B. DATE 11/6/69  |                           | 24C. NAME of CEMETERY or CREMATORY Parkwood   |   | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland               |  |
| 25A. DATE REC'D BY HEALTH DEPT. NOV 6 1969  |               | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D.  |                           | 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Baltimore, Maryland  |   | ADDRESS   |  |

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 10910

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

69 10910

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

STORY, THOMAS J

2. DATE AND HOUR OF DEATH

NOVEMBER 4, 1969

1:04 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

ST. AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

MARYLAND

B. COUNTY

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

2505 MOORE AVE 21234

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

12/02/17

9. AGE (in years  
last birthday)

51

10. Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

REFRIGERATION

10B. KIND OF BUSINESS OR INDUSTRY

ECKLOF REFRIGERATION MARYLAND

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

RAYMOND STORY

14. MOTHER'S MAIDEN NAME

LORETTA STORY (NEE NOONAN)

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NONE

16. SOCIAL  
SECURITY NO.

215-03-1314

17. INFORMANT

ADDRESS

ST. AGNES HOSPITAL RECORDS

18. DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

3-4 weeks

5-6 years

5-6 years

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (Indify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 27 19 69 to NOVEMBER 4 19 69  
that (I) (we) last saw the deceased alive on NOVEMBER 4 19 69 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

11-6-69

23C. PHYSICIAN'S  
NAME (Type)

23D. ADDRESS

BALTIMORE, MARYLAND 21229

ST. AGNES HOSPITAL; CATON &amp; WILKENS AVE

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

11/8/69

24C. NAME OF CEMETERY or CREMATORY

Most Holy Redeemer Cemetery

24D. LOCATION

(City, town, or county)

Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.

NOV 6 1969

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

Leonard J. Ryck Inc. 5305 Harford Rd. 21214

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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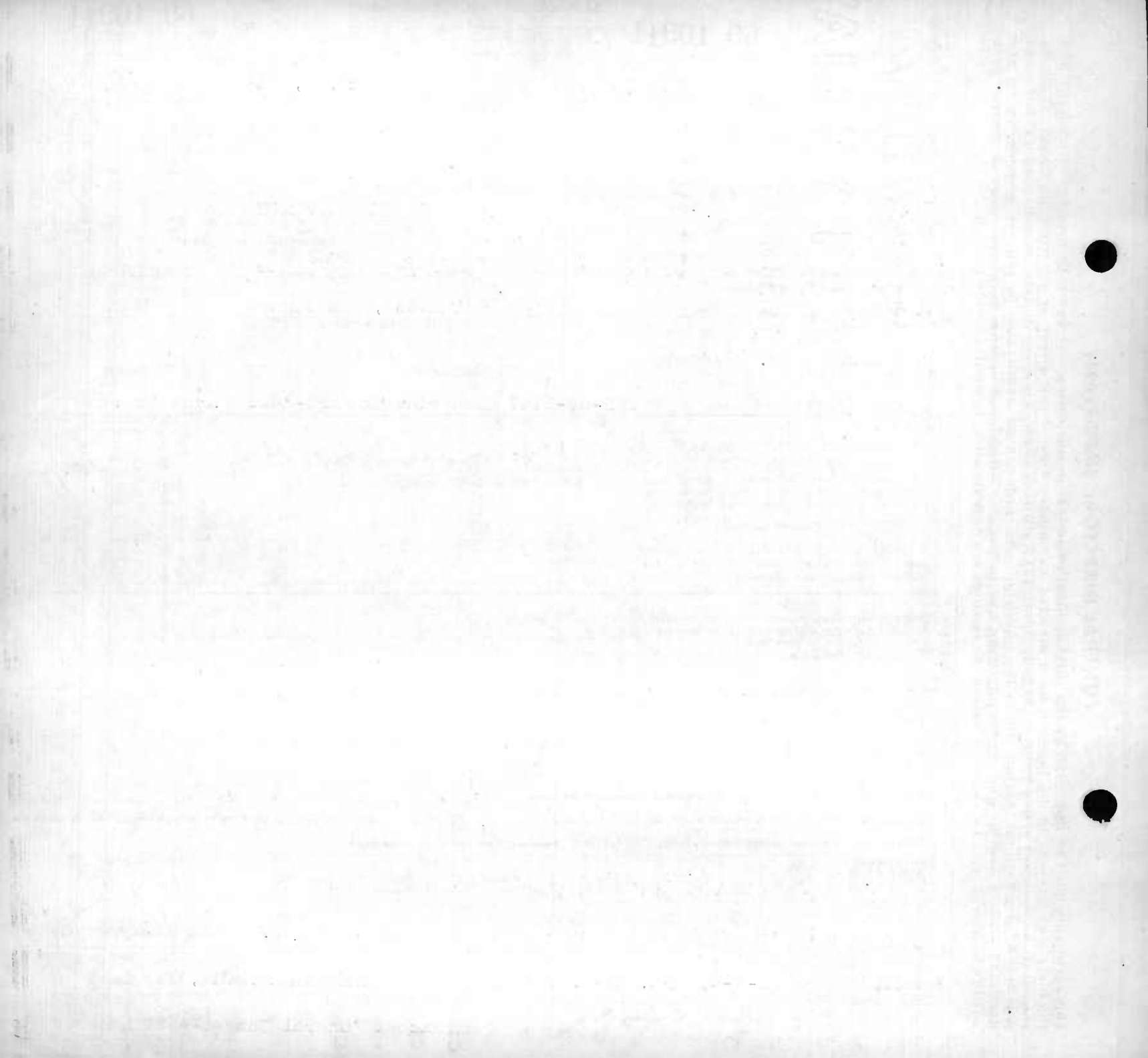
# 69 10911 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

69 10911

|   |         |  |  |  |  |
|---|---------|--|--|--|--|
| BIRTH NO.   |         | 1. NAME OF DECEASED<br>(Type or Print)   |  | 2. DATE AND HOUR OF DEATH  |  |
|   |         | IDA E Hadaway<br><del>HADAWAY</del>  |  | Oct. 31, 1969 10:20 p. M.  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |         |  | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)                                |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><br>60 2903 WAYNE AVENUE  |         |  | A. STATE MARYLAND B. COUNTY BALTIMORE 2802   |  |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |         |  | C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| E. STREET AND NUMBER 2903 WAYNE AVENUE  |         |  |  |  |  |
| 5. SEX  | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>                  | 8. DATE OF BIRTH   | 9. AGE (In years last birthday)  | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| FEMALE  | WHITE   | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                     | 3-12-1881  | 88   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |         | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)                                |  |
| Millinery   |         |  |  | Baltimore, Maryland  |  |
| 13. FATHER'S NAME   |         |  | 12. CITIZEN OF WHAT COUNTRY?   |  |  |
| William H. Hadaway  |         |  | USA  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |         |  | 16. SOCIAL SECURITY NO.  |  |  |
| NO  |         |  | 215-09-2147  |  |  |
| 17. INFORMANT   |         |  | ADDRESS  |  |  |
| Catherine Howard  |         |  | 2903 Wayne Avenue  |  |  |
| 18. CAUSE OF DEATH  |         |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH           |
| I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |         |  |  |  | 3 days   |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><i>Myocardial infarction</i>   |         |  |  |  |  |
| (B) DUE TO, OR AS A CONSEQUENCE OF:   |         |  |  |  |  |
| (C) DUE TO, OR AS A CONSEQUENCE OF:   |         |  |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |         |  |  |  |  |
| 19A. DATE OF OPERATION  |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)  |  |
|   |         |  |  | No   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
|   |         |  |  |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |
|   |         |  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 10/6 1958 to 10/31 1969, that (I) (we) last saw the deceased alive on 10/31 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.                                     |         |  |  |  |  |
| 23A. SIGNATURE<br>Robert A. Reiter, M.D.  |         |  |  | 23B. DATE SIGNED<br>11/1/69  |  |
| 23C. PHYSICIAN'S NAME (Type)<br>Robert A. Reiter, M.D.  |         |  |  | 23D. ADDRESS<br>606 Edmonson Ave. Baltimore, Md 21228                    |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |         | 24B. DATE  |  | 24C. NAME OF CEMETERY or CREMATORY                                       |  |
| Burial  |         | 11-4-69  |  | Mt. Olivet Cemetery  |  |
| 25A. DATE REC'D BY HEALTH DEPT.   |         | 25B. NAME OF REGISTRAR   |  | 25C. FUNERAL DIRECTOR  |  |
| NOV 6 1969  |         | Robert E. Fisher, R.D.   |  | Armacost Funeral Chapel-4600 Liberty Hts                                 |  |
| 24D. LOCATION (City, town, or county)   |         | 24E. LOCATION (State)  |  |  |  |
| Baltimore, Maryland   |         | Baltimore, Maryland  |  |  |  |





LAWRENCE COLLINS HAS BEEN RELEASED

AS FUNERAL DIRECTOR: IMPORTANT! THE MEDICAL EXAMINER'S

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 69 10912   |  |  |  | BALTIMORE CITY HEALTH DEPARTMENT   |  |   |  | X REG. NO. 69 10912  |  |   |  |
|--|--|--|--|--|--|---|--|--|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <u>Lawrence H. Collins, Sr.</u>   |  |  |  | 2. DATE AND HOUR OF DEATH<br><u>November 1, 1969</u> <u>5:07 P.</u> M.                                       |  |   |  |  |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                        |  |   |  |  |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>THE JOHNS HOPKINS HOSPITAL</u><br><u>BALTIMORE, MD 21205</u>  |  |  |  | A. STATE<br><u>MARYLAND</u>  |  |   |  | B. COUNTY<br><u>XXXXXXX BALTO.</u>   |  |   |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |  |  |  | C. CITY OR TOWN<br><u>XXXXXXX BALTO.</u>   |  |   |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |
| E. STREET AND NUMBER<br><u>604 CLEVELAND ROAD</u>  |  |  |  | F. CITY OR TOWN<br><u>XXXXXXX BALTO.</u>   |  |   |  | G. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |
| 5. SEX<br><u>MALE</u>  |  | 6. RACE<br><u>WHITE</u>                          |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                        |  | 8. DATE OF BIRTH<br><u>6-9-97</u>                                 |  | 9. AGE (In years last birthday)<br><u>72</u>   |  | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.                      |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Electrical Engr.</u>   |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Self</u> |  | 11. BIRTHPLACE (State or foreign country)<br><u>Baltimore, Maryland</u>                                      |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  |   |  |
| 13. FATHER'S NAME<br><u>Walter Collins</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><u>Adelaide Brooks</u>   |  |   |  |  |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>  |  |  |  | 16. SOCIAL SECURITY NO.<br><u>218-09-4777A</u>   |  |   |  | 17. INFORMANT<br><u>Mr. Carl N. Collins</u>  |  |   |  |
| ADDRESS<br><u>6427 Pinehurst Rd.</u>   |  |  |  |  |  |   |  |  |  |   |  |
| 18. <u>436.91</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><u>Arteriosclerotic accident</u>  |  |  |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><u>Arteriosclerotic accident</u> |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>one hour</u>                      |  |   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>Generalized Arteriosclerosis</u>  |  |  |  | (B) DUE TO, OR AS A CONSEQUENCE OF:<br><u>Generalized Arteriosclerosis</u>                                   |  |   |  | 10 years   |  |   |  |
| (C) _____  |  |  |  |  |  |   |  |  |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><u>Abdominal Aortic Aneurysm</u>   |  |  |  |  |  |   |  | 5 years  |  |   |  |
| 19A. DATE OF OPERATION<br><u>None</u>  |  |  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>_____  |  |   |  | 20A. AUTOPSY? (Yes or No)<br><u>no</u>   |  |   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><u>no</u>   |  |  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>_____            |  |   |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)<br>_____ |  |   |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX.)<br>_____  |  |  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>    |  |   |  | 21F. HOW DID INJURY OCCUR?<br>_____  |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>November 1, 1969</u> to <u>November 1, 1969</u> , that (I) (we) last saw the deceased alive on <u>November 1, 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |  |   |  |
| 23A. SIGNATURE<br><u>George H. Sack, Jr.</u>   |  |  |  |  |  |   |  | 23B. DATE SIGNED<br><u>11/1/69</u>   |  |   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>GEORGE H. SACK, JR.</u>   |  |  |  |  |  |   |  | 23D. ADDRESS<br><u>601 N. Broad way, Balto. Md 21205</u>                             |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  |  |  | 24B. DATE<br><u>11/4/69</u>  |  | 24C. NAME OF CEMETERY or CREMATORY<br><u>Loudon Park Cemetery</u> |  |  |  | 24D. LOCATION (City, town, or county) (State)<br><u>Baltimore, Maryland</u> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 6 1969</u>   |  |  |  | 25B. NAME OF REGISTRAR<br><u>Robert E. Taylor, M.D.</u>  |  |   |  | 25C. FUNERAL DIRECTOR<br><u>John A. Moran, Inc.</u>                                  |  |   |  |
|  |  |  |  |  |  |   |  | ADDRESS<br><u>3000 E. Baltimore St</u>   |  |   |  |

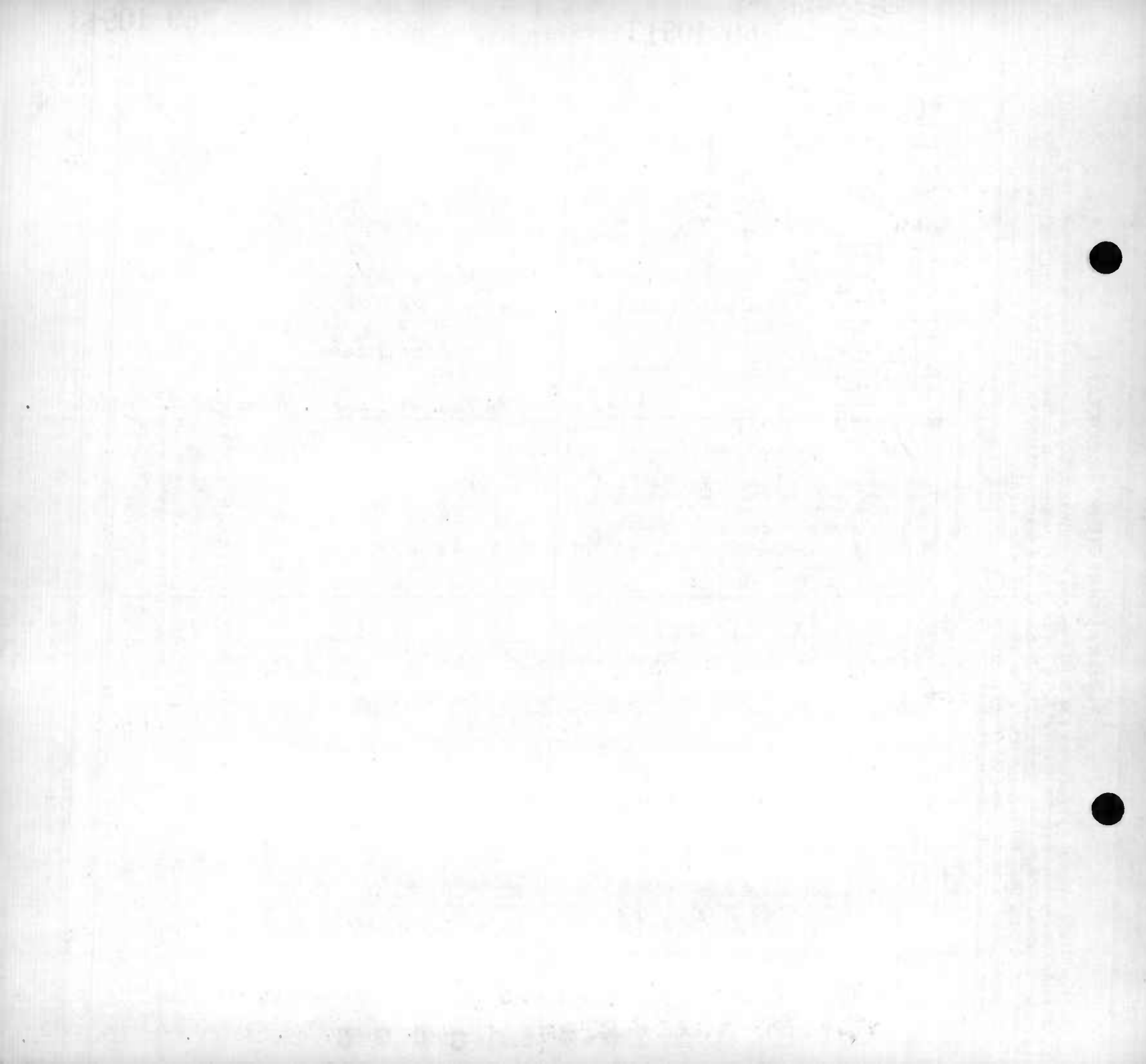


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 69 10913 CERTIFICATE OF DEATH

REG. NO. 69 10913

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| BIRTH NO.  |  | 1. NAME OF DECEASED<br>(Type or Print) <u>Bonday John H.</u>  |  | 2. DATE AND HOUR OF DEATH<br><u>Oct-31, 1969</u> <u>5:35 p.m.</u>   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>North Charles General Hosp.</u>   |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>2734 N. Charles St. Baltimore, Md. 21218</u>   |  | C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |
| E. STREET AND NUMBER<br><u>219 S. Bouldin St.</u>  |  | F. DATE OF BIRTH <u>11/10/87</u> G. AGE (In years last birthday) <u>87</u>  |  |   |  |
| 5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH  |  | 9. AGE (In years last birthday)   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired Shipping Clerk, Amer. Can</u>  |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA.</u>  |  | 13. FATHER'S NAME<br><u>John Bonday</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>Mary Marrow</u>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>  |  | 16. SOCIAL SECURITY NO.<br><u>212 09 509A</u>   |  | 17. INFORMANT<br><u>Mrs. Dolores T. Hahn</u>  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><u>Pneumonia ; Right</u><br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><u>Arteriosclerotic heart disease</u><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |   |  |   |  |
| 19A. DATE OF OPERATION   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Oct. 29</u> 19 <u>69</u> to <u>Oct. 31</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Oct. 31</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |   |  |   |  |
| 23A. SIGNATURE<br><u>V. Chitraplee</u>   |  |   |  | 23B. DATE SIGNED<br><u>Oct. 31, 1969</u>  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>V. Chitraplee</u>   |  |   |  | 23D. ADDRESS<br><u>North Charles General Hosp.</u>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 24B. DATE<br><u>11/3/69</u>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><u>Oak Town Cemetery</u>  |  |
| 24D. LOCATION (City, town, or county)<br><u>Baltimore, Maryland</u>  |  | 24E. FUNERAL DIRECTOR<br><u>John A. Marrow, Inc. 3000 C. Baltimore St.</u>  |  |   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 6 1969</u>   |  | 25B. NAME OF REGISTRAR<br><u>Robert E. Fisher, R.D.</u>   |  | 25C. ADDRESS<br><u>John A. Marrow, Inc. 3000 C. Baltimore St.</u>   |  |



1  
H-625

69 10914

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 10914

|   |                  |   |  |  |  |
|---|------------------|---|--|--|--|
| BIRTH NO.   |                  | 1. NAME OF DECEASED<br>(Type or Print) MARY HARRISON  |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> Nov. 1, 1969 M. |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>431 N. Highland Avenue  |                  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br>November 1, 1969 12:20 P.M.   |  | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland<br>B. COUNTY 2664 |  |
| 6. SEX<br>Female  | 7. RACE<br>White | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                       |  | C. CITY OR TOWN<br>Baltimore   |  |
| 9. DATE OF BIRTH<br>8-14-1904   |                  | 10. AGE (In years lost birthday) 65<br>If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.   |  | E. STREET AND NUMBER<br>431 N. Highland Avenue   |  |
| 11. BIRTHPLACE (State or foreign country)<br>Kentucky   |                  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 13. FATHER'S NAME<br>WESLEY COLLINS  |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>HOUSEWIFE  |                  | 14B. KIND OF BUSINESS OR INDUSTRY<br>HOME   |  | 15. MOTHER'S MAIDEN NAME<br>VINNIE SMITH   |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>No   |                  | 17. SOCIAL SECURITY NO.<br>-  |  | 18. INFORMANT<br>Mrs. Nellie Shave - 431 N. Highland Ave   |  |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>412.4<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>Arteriosclerotic Cardiovascular Disease<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |                  | CAUSE OF DEATH<br>Arteriosclerotic Cardiovascular Disease<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF: |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 20A. DATE OF OPERATION  |                  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 21. AUTOPSY? (Yes or No)<br>no   |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?   |  |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                  | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 22F. HOW DID INJURY OCCUR?   |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D.<br>EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.<br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED 11/2/69 |                  |   |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>BURIAL  |                  | 24B. DATE<br>11-5-69  |  | 24C. NAME of CEMETERY or CREMATORY<br>OAK LAWN CEM   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 6 1969   |                  | 25B. NAME OF REGISTRAR<br>Robert E. Farber, M.D.  |  | 25C. FUNERAL DIRECTOR<br>2334  |  |
| 24D. LOCATION (City, town, or county) (State)<br>BALTO., Md.  |                  |   |  |  |  |

1900 2

1900 1

Wesley Collins

James Smith

John

James

1900

1900 1

1900 1

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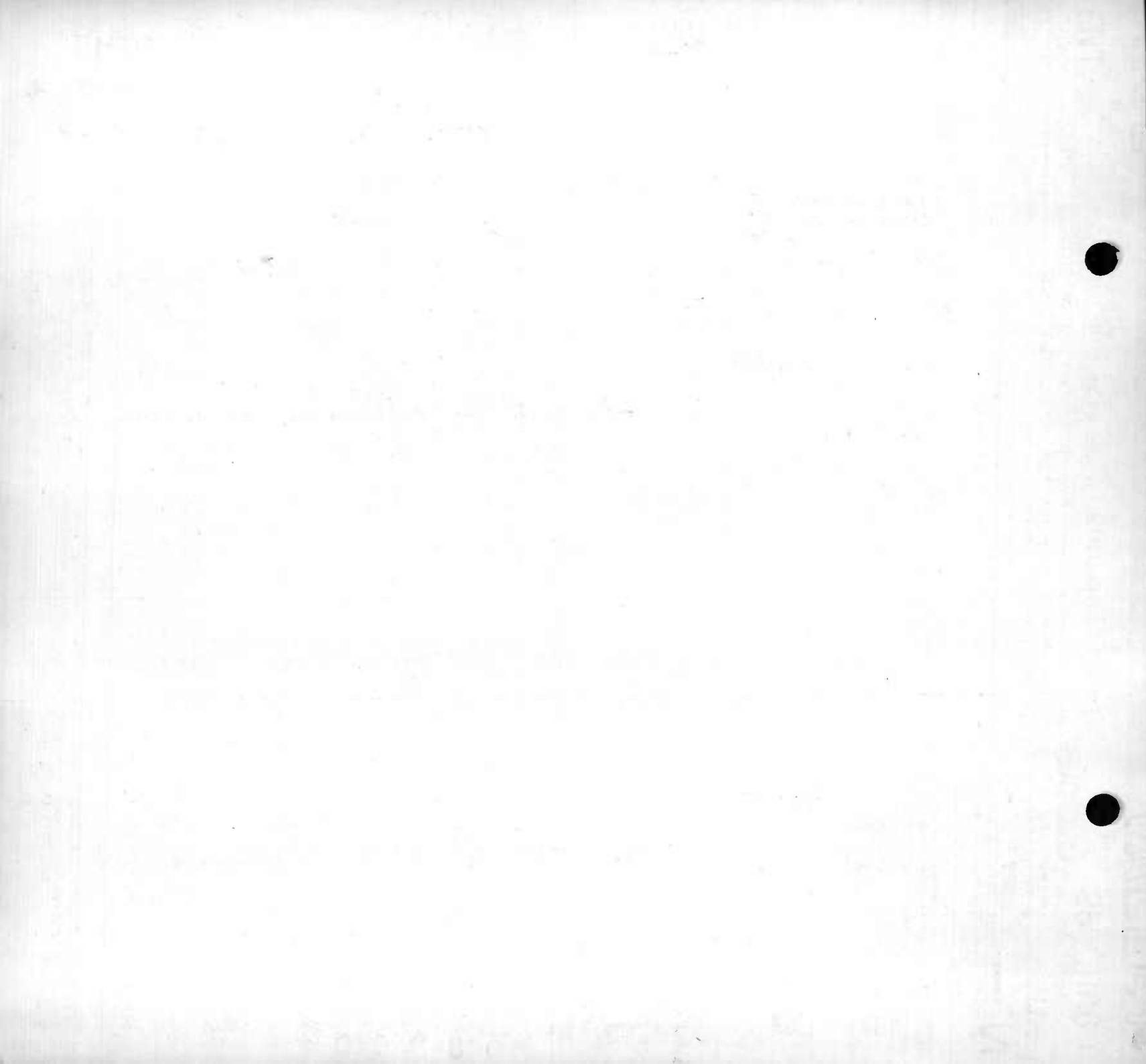
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                                 |  |                                 | REG. NO. <u>36</u>  |
|---|---------------------------------|--|---------------------------------|---|
| 69 10915 CERTIFICATE OF DEATH   |                                 |  |                                 | 69 10915  |
| BIRTH NO.   |                                 | 1. NAME OF DECEASED<br>(Type or Print) <u>Pantoulis, Anastasios</u>  |                                 | 2. DATE AND HOUR OF DEATH<br><u>11-2-69</u> <u>10:15 A.M.</u>                                 |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                                 | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>Md.</u> B. COUNTY <u>21224</u>  |                                 |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>Narbor View Nursing Home - 1213 Light St. Baltimore, Md.</u>   |                                 | C. CITY OR TOWN<br><u>Baltimore</u>  |                                 | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| E. STREET AND NUMBER<br><u>607 Oldham St.</u>   |                                 | <u>2607</u>  |                                 |   |
| 5. SEX<br><u>M</u>  | 6. RACE<br><u>white (Greek)</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><u>1882</u> | 9. AGE (In years last birthday)<br><u>87 yrs</u>  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired Dishwasher</u>  |                                 | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Restaurant</u>   |                                 | 11. BIRTHPLACE (State or foreign country)<br><u>Greece</u>                                    |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>   |                                 | 13. FATHER'S NAME<br><u>Narby Pantoulis</u>  |                                 |   |
| 14. MOTHER'S MAIDEN NAME<br><u>Unknown</u>  |                                 | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>  |                                 |   |
| 16. SOCIAL SECURITY NO.<br><u>218-01-4038</u>   |                                 | 17. INFORMANT<br><u>Harry Pantoulis 1800 Angelsea St., Baltimore, Md.</u>  |                                 |   |
| 18. <u>412.4 I</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><u>Arteriosclerotic Cardiovascular Disease</u><br>(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.<br><u>II</u> |                                 | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><u>Arteriosclerotic Cardiovascular Disease</u><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF: |                                 |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                                 |  |                                 |   |
| 19A. DATE OF OPERATION<br><u>0</u>  |                                 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                 | 20A. AUTOPSY? (Yes or No)   |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                                 | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |                                 |   |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                                 |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |                                 | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                                 | 21F. HOW DID INJURY OCCUR?  |
| 22. I certify that (1) this hospital attended the deceased from <u>Jan 31 1969</u> to <u>Nov 2 1969</u> , that (2) we last saw the deceased alive on <u>Jan 2 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.   |                                 |  |                                 |   |
| 23A. SIGNATURE<br><u>D.C. Alexizatos, M.D.</u>  |                                 | 23B. DATE SIGNED<br><u>11/2/69</u>   |                                 | 23C. PHYSICIAN'S NAME (Type)<br><u>D.C. ALEXIZATOS, M.D.</u>                                  |
| 23D. ADDRESS<br><u>1209 S. Paul St. Balt, Md 21202</u>  |                                 | 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                 |   |
| 24B. DATE<br><u>11-4-69</u>   |                                 | 24C. NAME OF CEMETERY OR CREMATORY<br><u>Greek Orthodox Cemetery</u>   |                                 | 24D. LOCATION (City, town, or county) (State)<br><u>Baltimore, Md.</u>                        |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 6 1969</u>  |                                 | 25B. NAME OF REGISTRAR<br><u>Robert E. Fisher, M.D.</u>  |                                 | 25C. FUNERAL DIRECTOR<br><u>Matthews Funeral Home</u>   |
| 25D. ADDRESS<br><u>Dockery &amp; Co.</u>  |                                 |  |                                 |   |





## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                         |   |  |   |   |
|---|-------------------------|---|--|---|---|
| BIRTH NO.   |                         | 1. NAME OF DECEASED<br>(Type or Print)<br><b>Eva Wilchinski</b>   |  | 2. DATE AND HOUR OF DEATH<br><b>11-3-69</b> <b>7:00 P.</b>                            |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Baltimore City Hospitals</b><br><b>4940 Eastern Ave.</b><br><b>Baltimore, Md. 21224</b>  |                         |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b><br>C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>E. STREET AND NUMBER <b>655 S. 48th St. 005</b> |   |   |
| 5. SEX<br><b>Female</b>   | 6. RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>3-1-1887</b>  | 9. AGE (In years last birthday)<br><b>82</b>  | If Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>   |                         | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Austria</b>                           |   |
| 13. FATHER'S NAME<br><b>?</b>   |                         |   | 14. MOTHER'S MAIDEN NAME<br><b>?</b>   |   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |                         | 16. SOCIAL SECURITY NO.<br><b>220-18-6577D</b>  |  | 17. INFORMANT<br><b>4940 Eastern Ave.</b><br><b>BCH Records: Baltimore, Md. 21224</b> |   |
| 18. <b>412.2 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>Pulmonary Embolus</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Arteriosclerotic Cardiovascular Disease</b><br><b>Hypertension, Cong. heart Failure</b> |                         |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 1/2 hours</b><br><b>years</b>   |   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |                         |   |  |   |   |
| 19A. DATE OF OPERATION<br><b>0</b>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><b>No</b>  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that <del>the</del> (this hospital) attended the deceased from <b>10-18-69</b> <b>1969</b> to <b>11-3-</b> <b>1969</b> .<br>that (I) (we) last saw the deceased alive on <b>11-3-</b> <b>1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <del>We</del> (We) (did) ( <del>did not</del> ) view the body after death.   |                         |   |  |   |   |
| 23A. SIGNATURE<br><b>Edw J Lee MD</b>   |                         |   | 23B. DATE SIGNED<br><b>11-3-69</b>   |   |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Edward J. Lee Md.</b>  |                         |   | 23D. ADDRESS<br><b>BCH: 4940 Eastern Ave. Baltimore, Md. 21224</b>   |   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 24B. DATE<br><b>II-6-1969</b>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Mount Carmel Cemetery</b>                    |   |
| 24D. LOCATION<br><b>Baltimore, Maryland</b>   |                         | 24E. LOCATION (City, town, or county) (State)   |  |   |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 6 1969</b>  |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor</b>   |  | 25C. FUNERAL DIRECTOR<br><b>WALTER DABROWSKI</b>                                      |   |
| 25D. ADDRESS<br><b>1005 DUNDALK AVENUE</b>  |                         |   |  |   |   |

230-14-4-113

10-10-113

11-10-113

11-10-113

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 69 10917 CERTIFICATE OF DEATH

REG. NO. 69 10917

|   |  |  |  |   |   |
|---|--|--|--|---|---|
| BIRTH NO.   |  | 1. NAME OF DECEASED<br>(Type or Print) <b>GREEN, MRS. KATHERINE A.</b>   |  | 2. DATE AND HOUR OF DEATH<br><b>NOVEMBER 3, 1969 3:20 P.M.</b>    |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br><b>Bon Secours Hospital</b>   |  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>2005</b> |   |   |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Bon Secours Hospital</b>  |  |  | C. CITY OR TOWN<br><b>Baltimore</b>  |   | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |
| 5. SEX<br><b>Female</b>   |  |  | 6. RACE<br><b>White</b>  |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH<br><b>APRIL 20, 1894</b>   |  | 9. AGE (In years last birthday)<br><b>75 yrs.</b>  |  | 10. UNDER 1 Yr. Months: Days: Hours: Min.                         |   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retiree</b>   |  |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  | 13. FATHER'S NAME<br><b>CHRISTOPHER LANG</b>   |   |   |
| 14. MOTHER'S MAIDEN NAME<br><b>WHITMAN, MARGARET</b>  |  |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>              |   |   |
| 16. SOCIAL SECURITY NO.<br><b>None</b>  |  |  | 17. INFORMANT<br><b>Chart Mr. Charles H. Green 350 S. Smallwood St. 21223</b>  |   |   |
| 18. <b>412.31</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>arteriosclerotic Heart disease</b>  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 years</b>   |   |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  |  | (B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:   |   |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |  |  |  |   |   |
| 19A. DATE OF OPERATION<br><b>0</b>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)<br><b>No</b>                            |   |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> |  |   |   |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                       |  |   |   |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)   |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>         |  | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (1) (this hospital) attended the deceased from <b>11/2/69</b> to <b>11/3/69</b> , that (1) (we) lost saw the deceased alive on <b>11/3/69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. |  |  |  |   |   |
| 23A. SIGNATURE<br><b>M. Abbas M.D.</b>  |  |  |  | 23B. DATE SIGNED<br><b>11/3/69</b>                                |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>mahmoud Abbas M.D.</b>   |  |  |  | 23D. ADDRESS<br><b>Bon Secours Hospital</b>                       |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 24B. DATE<br><b>11-6-69</b>  |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Loudon Park Cemetery</b> |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>   |  | 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 6 1969</b>   |  |   |   |
| 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor M.D.</b>  |  | 25C. FUNERAL DIRECTOR<br><b>Howard H. Hubbard 4107 Wilkens Ave. 21229</b>                                      |  |   |   |

2212

TSAPRAM, 15/11/53

5-145

69 10918

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 10918

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| BIRTH NO.   |  | 1. NAME OF DECEASED<br>(Type or Print) <b>MARY SPIELMAN</b>  |  | 2. DATE AND HOUR OF DEATH<br><b>Nov. 1, 1969 2 05 P.M.</b>  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>BALT.</b>  |  | 2716  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>42 SINAI HOSPITAL</b>  |  | C. CITY OR TOWN<br><b>BALT.</b>  |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |
| E. STREET AND NUMBER<br><b>PLEASANT MANOR NURSING HOME</b>  |  | 5. SEX<br><b>F</b>   |  | 6. RACE<br><b>W</b>   |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH<br><b>5/16/82</b>   |  | 9. AGE (in years last birthday)<br><b>87</b>  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 13. FATHER'S NAME<br><b>Samuel Smith</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary J. Randall</b>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>   |  | 16. SOCIAL SECURITY NO.<br><b>214-09-9313</b>  |  | 17. INFORMANT<br><b>Mrs. Evelyn Smith Hagerstown, Md.</b>   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>412.4 I</b> |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>Cerebral Vascular Accident 72 hrs</b><br>(B) <b>Atrial Fibrillation</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>ASCVD</b><br>(C) <b>Pneumonia</b>   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 19A. DATE OF OPERATION<br><b>0</b>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>   |  | 20A. AUTOPSY? (Yes or No)<br><b>—</b>   |  |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)<br><input type="checkbox"/>  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  | 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  |
| 21F. HOW DID INJURY OCCUR?  |  | 22. I certify that (I) (this hospital) attended the deceased from <b>Oct. 30 1969</b> to <b>Nov 1 1969</b><br>that (I) (we) last saw the deceased alive on <b>Nov 1 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. |  | 23A. SIGNATURE<br><b>Victor Borden, M.D.</b>  |  |
| 23B. DATE SIGNED<br><b>Nov. 1, 1969</b>   |  | 23C. PHYSICIAN'S NAME (Type)<br><b>VICTOR BORDEN, M.D.</b>   |  | 23D. ADDRESS<br><b>SINAI HOSPITAL</b>   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>burial</b>   |  | 24B. DATE<br><b>11-4-69</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>   |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Hagerstown, Md.</b>   |  | 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 6 1969</b>   |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>   |  |
| 25C. FUNERAL DIRECTOR<br><b>Minnich Funeral Home</b>  |  | ADDRESS<br><b>Hagerstown, Md.</b>  |  |   |  |

4615 Park HgHYS. Ave.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 69 10919 CERTIFICATE OF DEATH

REG. NO. 69 10919

|   |                         |  |                                      |  |  |
|---|-------------------------|--|--------------------------------------|--|--|
| BIRTH NO.   |                         | 1. NAME OF DECEASED<br>(Type or Print) <b>WILLIAM J. DEEGAN</b>  |                                      | 2. DATE AND HOUR OF DEATH<br><b>11/4/69 13:05 A.M.</b>                   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                         | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>2749</b>   |                                      | C. CITY OR TOWN <b>BALTIMORE</b>   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>UNION MEMORIAL HOSPITAL</b><br><b>44</b>   |                         | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                      | E. STREET AND NUMBER<br><b>1660 BURNWOOD Rd. 21212</b>                   |  |
| 5. SEX<br><b>MALE</b>   | 6. RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>6-19-1895</b> | 9. AGE (in years last birthday) <b>74</b>                                | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>PUBLIC</b>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>TRANSPORTATION</b>   |                                      | 11. BIRTHPLACE (State or foreign country)<br><b>ILLINOIS</b>             |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |                         | 13. FATHER'S NAME<br><b>DEEGAN</b>   |                                      | 14. MOTHER'S MAIDEN NAME<br><b>UNK.</b>                                  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>(?)</b>  |                         | 16. SOCIAL SECURITY NO.<br><b>369-07-4395</b>  |                                      | 17. INFORMANT<br><b>MARGARET B. DEEGAN - SAME</b>                        |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>162.1 I CARCINOMA, PULMONARY</b>  |                         | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>PANCOST TUMOR</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>PERIPHERAL NEUROPATHY</b><br>(C) <b>METASTATIC CA OF THE RIBS</b> |                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>J. Fabry</b>          |  |
| MEDICAL CERTIFICATION   |                         |  |                                      |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>II METASTATIC CA OF THE RIBS</b>   |                         |  |                                      |  |  |
| 19A. DATE OF OPERATION<br><b>2</b>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                      | 20A. AUTOPSY? (Yes or No)  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)  |                                      | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                                      | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 4 1969</b> to <b>NOVEMBER 4 1969</b> that (I) (we) last saw the deceased alive on <b>NOV. 4 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |  |                                      |  |  |
| 23A. SIGNATURE<br><b>YLI SUI LIT</b>  |                         |  |                                      | 23B. DATE SIGNED<br><b>NOV.</b>  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>YLI SUI LIT</b>  |                         | 23D. ADDRESS<br><b>UNION MEMORIAL HOSPITAL, BALTIMORE MD</b>   |                                      |  |  |
| 24A. FINAL CREMATION, REMOVAL (Specify)<br><b>CREMATION</b>   |                         | 24B. DATE<br><b>11-5-69</b>  |                                      | 24C. NAME of CEMETERY or CREMATORY<br><b>GREENMOUNT</b>                  |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>BALTIMORE, MD</b>   |                         | 25A. DATE REC'D. BY HEALTH DEPT.<br><b>NOV 6 1969</b>  |                                      |  |  |
| 25B. NAME OF REGISTRAR<br><b>Robert E. Fabry, M.D.</b>  |                         | 25C. FUNERAL DIRECTOR<br><b>W. Brooks Bradley, Dundalk, MD</b>   |                                      |  |  |





# FUNERAL DIRECTOR: IMPORTANT

54-71-86 1

BALTIMORE CITY HEALTH DEPARTMENT

69 10920 CERTIFICATE OF DEATH

REG. NO. 69 10920

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

MALLIE M. BOVA

2. DATE AND HOUR OF DEATH

11/2/69

6 25 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITAL  
4940 Eastern Avenue Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)  
A. STATE B. COUNTY

MD

HARFORD

C. CITY OR TOWN

ABERDEEN

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

RT 1

21001

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

1-22-1898

9. AGE (In years last birthday)

71

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Virginia (Galax)

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Shores

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

215-32-5537

17. INFORMANT

4940 Eastern Avenue  
BCH: Records Baltimore, Maryland 21224

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE CARCINOMA OF CERVIX  
DUE TO, OR AS A CONSEQUENCE OF: METASTASES

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

~ 6 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSE OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (initially medical examined)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/2/69 to 11/2/69 that (I) (we) last saw the deceased alive on 11/2/69 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

R. K. Maza

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

11/2/69

23C. PHYSICIAN'S NAME (Type)

R. K. Maza

23D. ADDRESS

Baltimore City Hospitals  
4940 Eastern Avenue Baltimore, Maryland 21224  
Bel Air, Harford Co., Maryland

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11-5-69

24C. NAME OF CEMETERY OR CREMATORY

Bel Air Memorial Gardens

24D. LOCATION

Bel Air, Harford Co., Maryland

25A. DATE REC'D BY HEALTH DEPT.

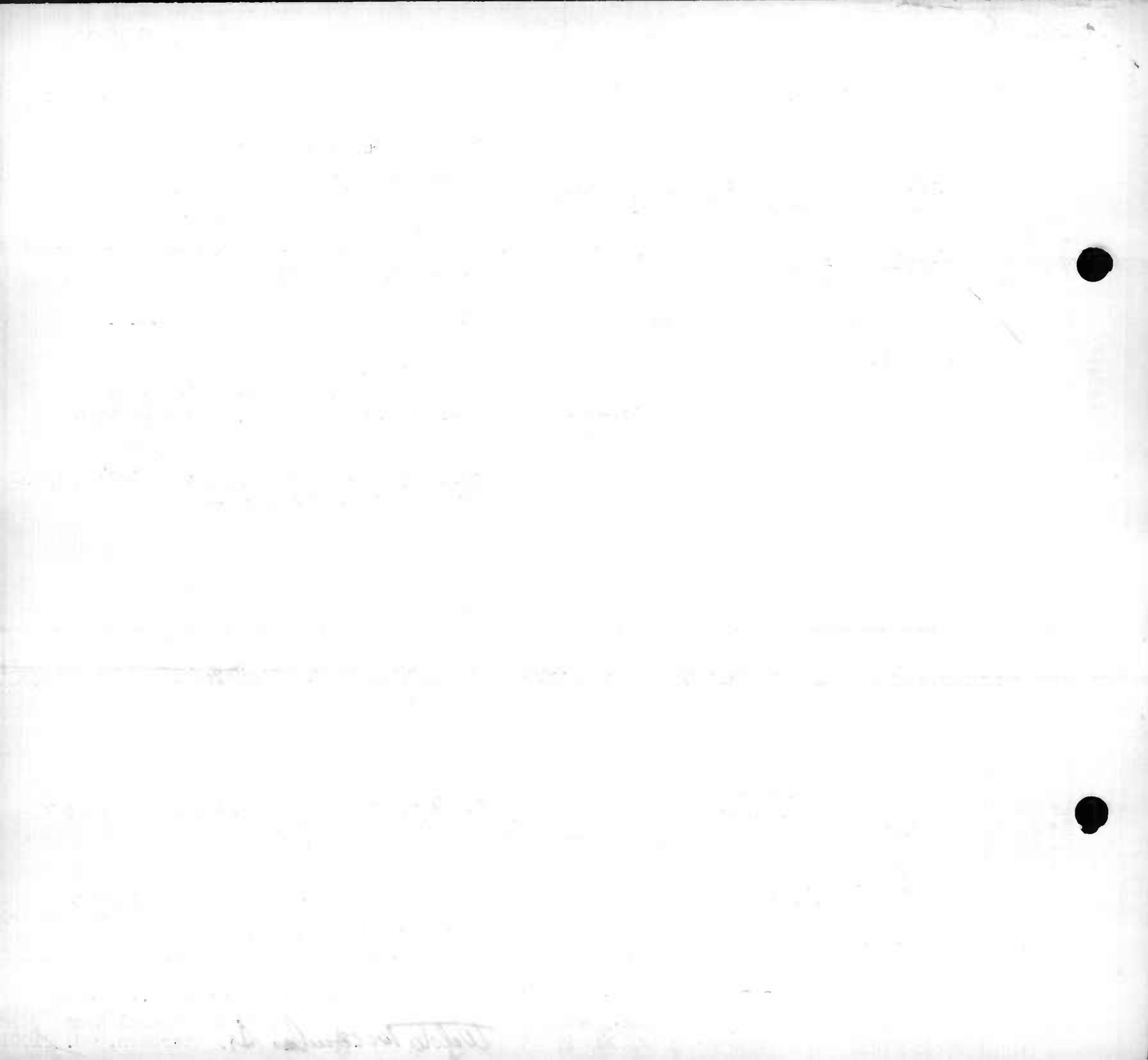
NOV 6 1969

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Tarrying Funeral Home  
Aberdeen, Md. 21001



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |  |  |   | REG. NO. 69 10921  |   |
|--|--|--|---|--|---|
| BIRTH NO.  |  | 69 10921   |   | CERTIFICATE OF DEATH   |   |
| 1. NAME OF DECEASED<br>(Type or Print) GRIFFIN SUE B.  |  |  | 2. DATE AND HOUR OF DEATH<br>November 5 1969 12.15 A.M.   |  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE MARYLAND B. COUNTY 1202 |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>44 UNION MEMORIAL HOSPITAL  |  |  | C. CITY OR TOWN<br>BALTIMORE  |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |
| 5. SEX<br>FEMALE   |  |  | 6. RACE<br>WHITE  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>CLERK   |  |  | 10B. KIND OF BUSINESS OR INDUSTRY<br>INSURANCE COMPANY  |  | 8. DATE OF BIRTH<br>06-29-83  |
| 13. FATHER'S NAME<br>XXXXXXXXXXXX J. Frank Griffin   |  |  | 14. MOTHER'S MAIDEN NAME<br>RAWLINGS  |  | 9. AGE (in years last birthday) 86<br>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |  |  | 6. SOCIAL SECURITY NO.<br>215-07-8833   |  | 11. BIRTHPLACE (State or foreign country)<br>MARYLAND   |
| 17. INFORMANT<br>Mr. Frank Griffin 7533 Westfield Rd.<br>ROSA LEE GRIFFIN (NIECE)  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  |   |
| 18. CAUSE OF DEATH   |  |  |   |  |   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  |  |   |  |   |
| (A) IMMEDIATE CAUSE CARDIAC ARREST<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) Septicemic Shock<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) Acute diverticulitis   |  |  |   |  |   |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |   |  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |  |   |  |   |
| 19A. DATE OF OPERATION<br>0  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No)<br>NO  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from October 28 1969 to November 5 1969 that (I) (we) last saw the deceased alive on November 5 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.       |  |  |   |  |   |
| 23A. SIGNATURE<br>Miguel Karacuschansky M.D.   |  |  |   | 23B. DATE SIGNED<br>November 5, 1969                                     |   |
| 23C. PHYSICIAN'S NAME (Type)<br>Miguel KARACUSCHANSKY M.D.   |  |  |   | 23D. ADDRESS<br>UNION MEMORIAL Hospital                                  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial   |  | 24B. DATE<br>11-7-1969   |   | 24C. NAME of CEMETERY or CREMATORY<br>Loudon Park Cemetery               |   |
| 24D. LOCATION<br>Baltimore, Maryland   |  | 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 6 1969  |   |  |   |
| 25B. NAME OF REGISTRAR<br>R. E. J. J. J.   |  | 25C. FUNERAL DIRECTOR<br>Howard H. Hubbard, 4107 Wilkens Ave. 21229                                    |   |  |   |

9 2 9

2001 N CHARLES STREET

00-14-83 82

U.S.A.

MARYLAND

REMAINING

ALANEE GRIFFIN (WIFE)

Starting Point

Grassman Park  
11th Street

NO

2 10 1983

2 10 1983

My handwriting

My handwriting

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO.  |                     | 69 10922 CERTIFICATE OF DEATH   |   | REG. NO. 69 10922  |   |
|--|---------------------|---|---|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>JENKINS, THOMAS J</b>  |                     |   | 2. DATE AND HOUR OF DEATH<br><b>11-2-69 2:50pm</b>  |  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                     |   | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)                                       |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>North Charles Gen. Hosp</b><br><b>28th at Charles St</b>  |                     |   | A. STATE <b>MD.</b> B. COUNTY <b>Balto</b>  |  |   |
|  |                     |   | C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |
| E. STREET AND NUMBER<br><b>347 Bigley Ave, Riverview, MD</b>   |                     |   |   |  |   |
| 5. SEX<br><b>M</b>   | 6. RACE<br><b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2-6-13</b>   | 9. AGE (In years last birthday)<br><b>56</b>                             | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Guard</b>  |                     | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Museum of Art</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Penna</b>                |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |                     |   |   |  |   |
| 13. FATHER'S NAME<br><b>William J. Jenkins</b>   |                     |   | 14. MOTHER'S MAIDEN NAME<br><b>Hotz Cunningham</b>  |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>yes WWII-</b>   |                     |   | 16. SOCIAL SECURITY NO.<br><b>345-12-6081</b>   |  | 17. INFORMANT<br><b>Hospital Chart</b>                    |
| 18. <b>185 X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>Chronic renal failure &amp; pulmonary edema</b>  |                     |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                     |   | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>arterial atherosclerosis &amp; pyelonephritis</b>              |  |   |
|  |                     |   | (B) DUE TO, OR AS A CONSEQUENCE OF:   |  |   |
|  |                     |   | (C) _____   |  |   |
| <b>II</b>  |                     |   |   |  |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>Ca, prostate</b>  |                     |   |   |  |   |
| 19A. DATE OF OPERATION<br><b>10-23-69</b>  |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Prostatic Ca</b>   |   | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>            |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>   |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                     | 21E. INJURY OCCURRED<br>White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>   |   | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10-17-69</b> to <b>11-2-69</b> , that (I) (we) last saw the deceased alive on <b>11-2-69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. |                     |   |   |  |   |
| 23A. SIGNATURE<br><b>Juan Jan, MD</b>  |                     |   |   | 23B. DATE SIGNED<br><b>11-2-69</b>                                       |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Juan Jan, MD</b>  |                     |   |   | 23D. ADDRESS<br><b>North Charles Gen. Hosp.</b>                          |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                     | 24B. DATE<br><b>11/5/69</b>   |   | 24C. NAME OF CEMETERY, or CREMATORY<br><b>Woodlawn Park</b>              |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>Elkridge R. &amp; D Md.</b>  |                     |   |   |  |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 6 1969</b>   |                     | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, MD.</b>  |   | 25C. FUNERAL DIRECTOR<br><b>E.B. H.</b>                                  |   |
|  |                     |   |   | ADDRESS<br><b>2401 E. Federal Ave, Glen Burnie, Md.</b>                  |   |



W-452

69 10923

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 10923

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

John G. Williams Jr.

2. DATE  
OF  
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

37 Mercy Hospital

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

11

2

69

2:00 P

M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

1203

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

A-4-1933

10. AGE (In years  
lost birthday)

36

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

2613 N. Calvert Street

11. BIRTHPLACE (State or foreign country)

Wilkeborra Penna.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John G.H. Williams Sr.

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Printer

14B. KIND OF BUSINESS OR INDUSTRY

News American

15. MOTHER'S MAIDEN NAME

Esther Jones

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

212-30-5951

18. INFORMANT

John G.H. Williams Sr. 6503 Hazelwood Ct.

ADDRESS

2;237

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Subdural hematoma

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

Midway Bar

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

421 E. Baltimore St.

22D. TIME  
OF INJURY  
(APPROX.)

(Month)

9

(Day)

16

(Year)

69

(Hour)

8:50A

22E. INJURY OCCURRED

WHILE AT  
m. WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject fell down stairs

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒  
ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11-3-69

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

11-5-1969

24C. NAME OF CEMETERY or CREMATORY

Moreland Park

24D. LOCATION (City, town, or county)

Baltimore, Balto.

(State)

Md

25A. DATE REC'D BY HEALTH DEPT.

NOV 6 1969

25B. NAME OF REGISTRAR

J. E. Fisher, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

Lassahn Funeral Home 7401 Belair Road 21236

VSI77 Dr. Fisher



6-200

69 10924

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 10924

BIRTH NO.

CERTIFICATE AMENDED-11/13/69

|   |                             |   |   |
|---|-----------------------------|---|---|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>DORSEY GASSAWAY</b>  |                             | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Estimated <input type="checkbox"/><br>Month Day Year Hour<br><b>November 4, 1969 7:30 P.</b>             |   |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Rear of 200 Ridgewood Road</b>   |                             | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>November 4, 1969 7:30 P.</b>   |   |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>  |                             | C. CITY OR TOWN <b>Towson</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                    |   |
| 6. SEX<br><b>Male</b>   | 7. RACE<br><b>White</b>     | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 9. DATE OF BIRTH<br><b>Feb. 2, 1940</b>   |                             | 10. AGE (In years lost birthday) <b>29</b><br># Under 1 Yr. II Under 24 Hrs.<br>Months Days Hours Min.  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                             | 12. CITIZEN OF<br><b>U.S.A.</b>   |   |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Social Worker</b>   |                             | 14B. KIND OF BUSINESS OR INDUSTRY   |   |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or doles of service)<br><b>No</b>  |                             | 17. SOCIAL SECURITY NO.<br><b>212-42-9859</b>   |   |
| 18. INFORMANT<br><b>Mrs. Bonnie Gassaway</b>  |                             | ADDRESS<br><b>Same as # 5 E</b>   |   |
| 19. CAUSE OF DEATH<br><b>E953 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Gunshot wound of head</b><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____   |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                             |   |   |
| 20A. DATE OF OPERATION  |                             | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                             | 22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)<br><b>Car</b>  |   |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br><b>Rear of 200 Ridgewood Road</b>   |                             | 22F. HOW DID INJURY OCCUR?<br><b>Self-inflicted gunshot wound of head</b>   |   |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)<br><b>Unk.</b>  |                             | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |   |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D.<br>NAME (Type) <b>Ronald N. Kornblum, M.D.</b><br>DATE SIGNED <b>11/5/69</b> |                             |   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 24B. DATE<br><b>11-7-69</b> | 24C. NAME OF CEMETERY or CREMATORY<br><b>Druid Ridge Cemetery</b>   | 24D. LOCATION (City, town, or county) (State)<br><b>Pikesville Maryland</b> |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 6 1969</b>  |                             | 25B. NAME OF REGISTRAR<br><b>Robert E. Farber, M.D.</b>   |   |
| 25C. FUNERAL DIRECTOR<br><b>Wm. Cook-Brooks Towson, Inc.</b>  |                             | ADDRESS<br><b>Towson, Md.</b>   |   |

11/13/69 - Correction form from funeral director.

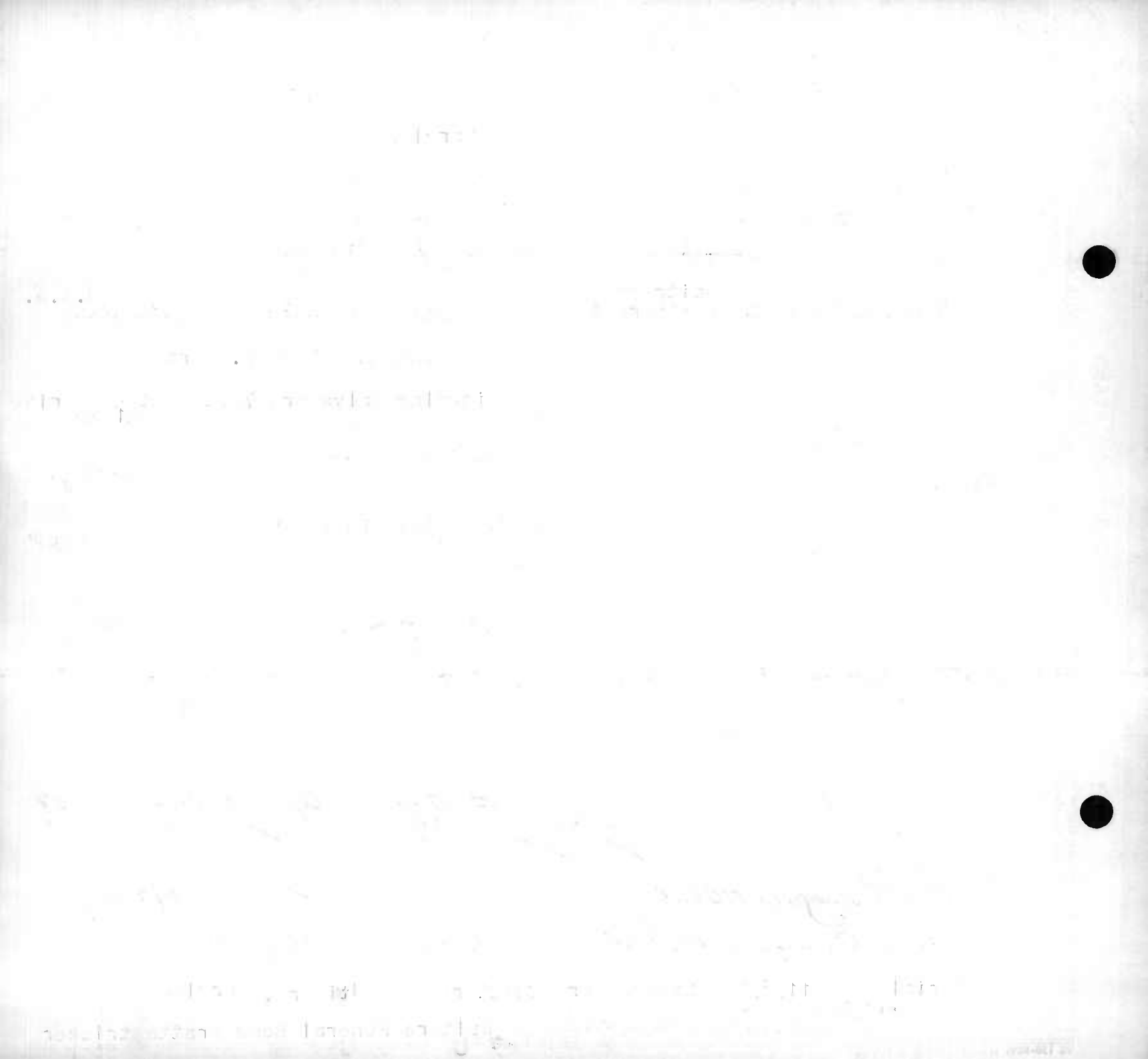
*Be*

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO.   |                  | BALTIMORE CITY HEALTH DEPARTMENT<br>69 10925 CERTIFICATE OF DEATH   |   | REG. NO. 69 10925  |   |
|---|------------------|---|---|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <u>BUCK, MARIE</u>   |                  |   | 2. DATE AND HOUR OF DEATH<br><u>11-2-69</u> <u>6:55 PM</u> M.   |  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>Bon Secours Hospital</u><br><u>200 W. Baltimore St</u>  |                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>Maryland</u><br>B. COUNTY <u>1903</u><br>C. CITY OR TOWN <u>Balto, md</u><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <u>Balto, md 407 S. Mount St</u> |  |   |
| 5. SEX <u>F</u>   | 6. RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>aug-9-09</u>  | 9. AGE (in years lost birthday) <u>60</u>                                    | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>XXXXXXXXXXXXXXX</u>   |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Waitress Restaurant</u>   |   | 11. BIRTHPLACE (State or foreign country)<br><u>XXXXXXXXX RUMANIA</u>        |   |
| 13. FATHER'S NAME<br><u>John Zebelean</u>   |                  | 14. MOTHER'S MAIDEN NAME<br><u>XXXXXXXXX Rose A. Bura</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A. XXXXXXXXXX</u>                     |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>no</u>   |                  | 16. SOCIAL SECURITY NO.<br><u>213-26-1440</u>   |   | 17. INFORMANT ADDRESS<br><u>Nicholas Salvadore 7904 West End Drive 21226</u> |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><u>5601 I</u><br><u>Garolytic ileus</u><br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><u>Acute peritonitis</u><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><u>Bronchopneumonia</u><br>(C) _____ |                  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>days</u><br><u>days</u><br><u>days</u>   |  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                  |   |   |  |   |
| 19A. DATE OF OPERATION<br><u>10/23/69</u>   |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>Abdominal Flau</u>   |   | 20A. AUTOPSY? (Yes or No) <u>Yes</u>   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Noted medical examiner) <u>NOT</u>   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)     |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |   | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that <u>if</u> (this hospital) attended the deceased from <u>10 July</u> 19 <u>69</u> to <u>2 Nov</u> 19 <u>69</u> that (I) <u>we</u> lost saw the deceased alive on <u>2 Nov</u> 19 <u>69</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (did) (did not) view the body after death.                                 |                  |   |   |  |   |
| 23A. SIGNATURE<br><u>W.L. Caulfield M.B.Ch.B.</u>   |                  |   | 23B. DATE SIGNED<br><u>11/2/69</u>  |  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |
| 23C. PHYSICIAN'S NAME (Type)<br><u>W.L. Caulfield M.B.Ch.B.</u>   |                  |   | 23D. ADDRESS<br><u>Bon Secours Hospital</u>   |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                  | 24B. DATE<br><u>11/6/69</u>   |   | 24C. NAME OF CEMETERY or CREMATORY<br><u>Loudon Park Cemetery</u>            |   |
| 24D. LOCATION<br><u>Baltimore, Maryland</u>   |                  | 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 6 1969</u>  |   |  |   |
| 25B. NAME OF REGISTRAR<br><u>Robert E. Fisher, R.D.</u>   |                  | 25C. FUNERAL DIRECTOR ADDRESS<br><u>Walters Funeral Home Pratt &amp; Stricker Sts.</u>  |   |  |   |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# B-525

## 69 10926 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

69 10926

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Charles Wilbur Benson

2. DATE AND HOUR OF DEATH

Nov. 2, 1969

7 P.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

8. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1109 Carroll St.

5. SEX

male

6. RACE

white

7. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

Feb. 26, 1899

9. AGE (In years lost birthday)

70 yrs.

If Under 1 Yr. Months: Days:

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR INDUSTRY

Canton Railroad Co. Balto. Md.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John E. Benson

14. MOTHER'S MAIDEN NAME

Jessie M. Cook

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown)

yes

(If yes, give war or dates of service)

World War I

16. SOCIAL SECURITY NO.

705-10-9266

17. INFORMANT

ADDRESS

Lillian Sullivan 1109 Carroll St.

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Coronary Thrombosis

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 day

5 yrs

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10/10 1964 to 11/2 1969 that (I) (we) last saw the deceased alive on 11/2/69 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Joseph G. Laukaitis MD

DEGREE

Attending Phys. ☒Med. Director ☐Staff Phys. ☐

23B. DATE SIGNED

11/4/69

23C. PHYSICIAN'S NAME (Type)

JOSEPH G. LAUKAITIS MD

DEGREE

23D. ADDRESS

679 Washington Blvd Baltimore Md

24A. BURIAL CREMATION REMOVAL (Specify)

Burial

24B. DATE

11/6/69

24C. NAME OF CEMETERY or CREMATORY

Loudon Park Cemetery

24D. LOCATION

(City, town, or county)

(State)

Frederick Ave. Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.

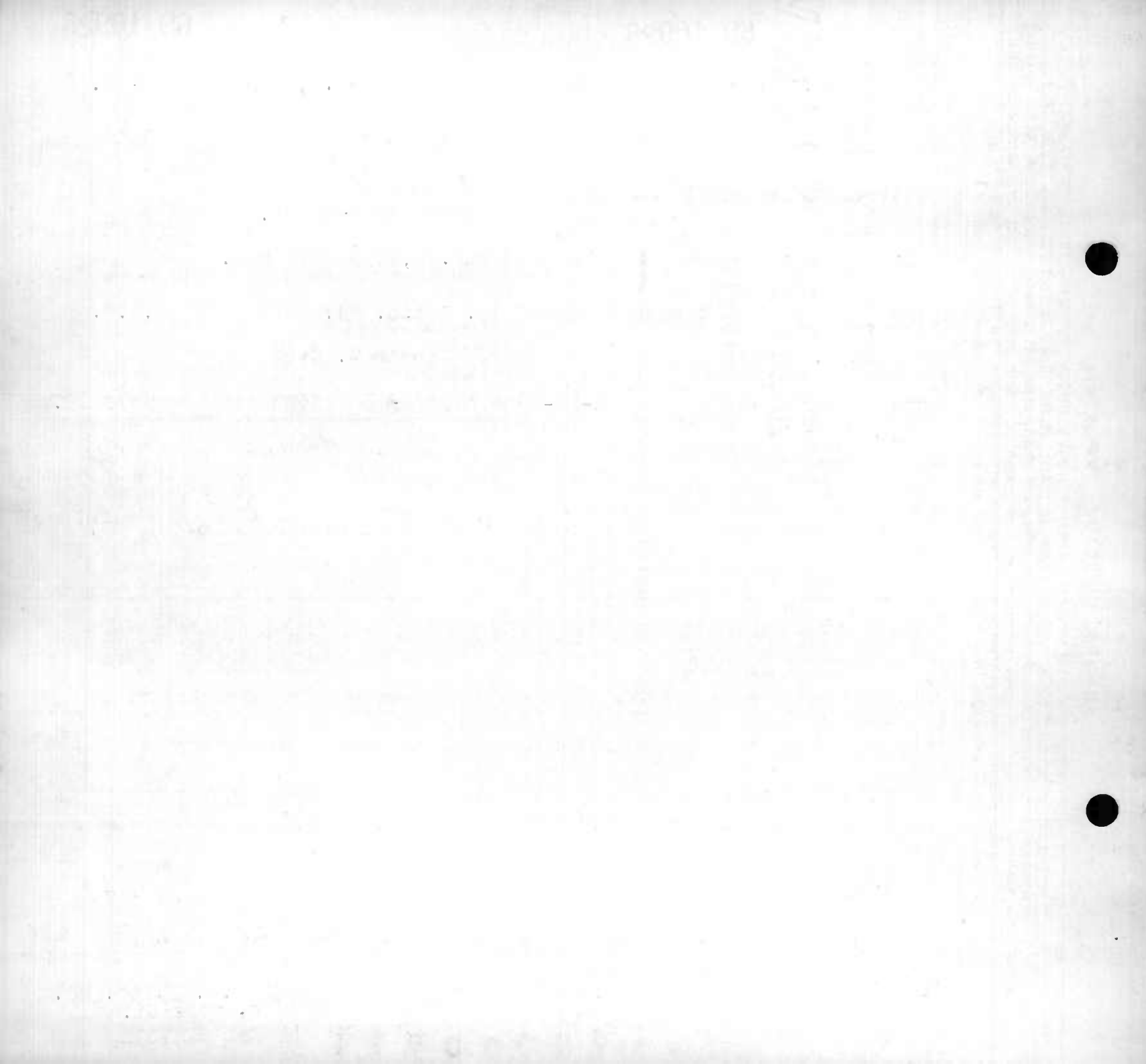
NOV 6 1969

25B. NAME OF REGISTRAR

Robert E. Taylor, MD

25C. FUNERAL DIRECTOR 1126 W. Cross St. ADDRESS

SCHWEINSBERG FUNERAL SERVICE



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |  |         |   |  |   |  |  |                                 |  |                                  |  |
|--|--|---------|---|--|---|--|--|---------------------------------|--|----------------------------------|--|
| 69 10927 CERTIFICATE OF DEATH  |  |         |   |  | Registered No. 69 10927   |  |  |                                 |  |                                  |  |
| BIRTH NO. <span style="float: right;">M.E. CASE NO.</span>   |  |         |   |  | 1. NAME OF DECEASED   |  |  |                                 |  |                                  |  |
|  |  |         |   |  | 2. DATE AND HOUR OF DEATH   |  |  |                                 |  |                                  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |  |         |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |  |  |                                 |  |                                  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  |  |         |   |  | A. STATE B. COUNTY  |  |  |                                 |  |                                  |  |
| 48 Maryland General  |  |         |   |  | MD - Balto 5300   |  |  |                                 |  |                                  |  |
|  |  |         |   |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)               |  |  |                                 |  |                                  |  |
|  |  |         |   |  | Balto   |  |  |                                 |  |                                  |  |
|  |  |         |   |  | D. STREET ADDRESS (If rural, give location)   |  |  |                                 |  |                                  |  |
|  |  |         |   |  | 2704 Garnet Rd.   |  |  |                                 |  |                                  |  |
| 5. SEX   |  | 6. RACE |   | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) |   | 8. DATE OF BIRTH   |  | 9. AGE (In years last birthday) |  |                                  |  |
| M  |  | W       |   | MARRIED  |   | 12/2/1899  |  | 69                              |  |                                  |  |
|  |  |         |   |  |   |  |  | If Under 1 Yr. Months Days      |  |                                  |  |
|  |  |         |   |  |   |  |  | If Under 24 Hrs. Hours Min.     |  |                                  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |         | 10B. KIND OF BUSINESS OR INDUSTRY   |  |   | 11. BIRTHPLACE (State or foreign country)                                |  |                                 | 12. CITIZEN OF WHAT COUNTRY?   |                                  |  |
| Conductor  |  |         | Rail Road   |  |   | Md   |  |                                 | USA  |                                  |  |
| 13. FATHER'S NAME  |  |         |   |  |   | 14. MOTHER'S MAIDEN NAME   |  |                                 |  |                                  |  |
| Henry C Weitzel  |  |         |   |  |   | Mary   |  |                                 |  |                                  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |  |         |   |  |   | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS           |  |                                  |  |
| yes  |  |         |   |  |   |  |  | ANNA P. Weitzel Same            |  |                                  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  |  |         |   |  |   | CAUSE OF DEATH   |  |                                 |  | INTERVAL BETWEEN ONSET AND DEATH |  |
| I 162.1  |  |         |   |  |   | Carcinoma, Bronchogenic  |  |                                 |  | Unknown                          |  |
|  |  |         |   |  |   | (A) DUE TO   |  |                                 |  |                                  |  |
|  |  |         |   |  |   | (B) DUE TO   |  |                                 |  |                                  |  |
|  |  |         |   |  |   | (C) DUE TO   |  |                                 |  |                                  |  |
| ANTECEDENT CAUSES  |  |         |   |  |   |  |  |                                 |  |                                  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  |         |   |  |   |  |  |                                 |  |                                  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |         |   |  |   |  |  |                                 |  |                                  |  |
| 19A. DATE OF OPERATION   |  |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20A. AUTOPSY? (Yes or No)  |  |                                 | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                  |  |
| 2  |  |         |   |  |   | YES  |  |                                 | YES  |                                  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) |  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |                                 |  |                                  |  |
|  |  |         |   |  |   |  |  |                                 |  |                                  |  |
| 21D. TIME OF INJURY (APPROX.)  |  |         | 21E. INJURY OCCURRED  |  |   | 21F. HOW DID INJURY OCCUR?   |  |                                 |  |                                  |  |
| (Month) (Day) (Year) (Hour)  |  |         | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>       |  |   |  |  |                                 |  |                                  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 10/15/69 to 11/4/69, that (I) (we) last saw the deceased alive on 11/4/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |         |   |  |   |  |  |                                 |  |                                  |  |
| 23A. SIGNATURE   |  |         |   |  |   | 23B. DATE SIGNED   |  |                                 |  |                                  |  |
| Michael Yen  |  |         |   |  |   | 11/4/69  |  |                                 |  |                                  |  |
| 23C. PHYSICIAN'S NAME (Type)   |  |         |   |  |   | 23D. ADDRESS   |  |                                 |  |                                  |  |
| MICHAEL YEN MD   |  |         |   |  |   | 827 Linden Ave. MD   |  |                                 |  |                                  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |  |         | 24B. DATE   |  |   | 24C. NAME OF CEMETERY or CREMATORY                                       |  |                                 | 24D. LOCATION (City, town, or county) (State)                        |                                  |  |
| BURIAL   |  |         | 11-5-69   |  |   | Dulaney Valley   |  |                                 | Balto Md   |                                  |  |
| 25A. DATE REC'D BY HEALTH DEPT.  |  |         | 25B. NAME OF REGISTRAR  |  |   | 25C. FUNERAL DIRECTOR  |  |                                 | ADDRESS  |                                  |  |
| NOV 6 1969   |  |         | Robert E. Farber, M.D.  |  |   | Chas. F. Evans, Jr.  |  |                                 | 8802 Hartford Rd   |                                  |  |

seat ca

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Act 3

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1. The first part of the  
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names and addresses of  
the members of the  
committee.

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the members of the  
committee.



FUNERAL DIRECTOR: IMPORTANT

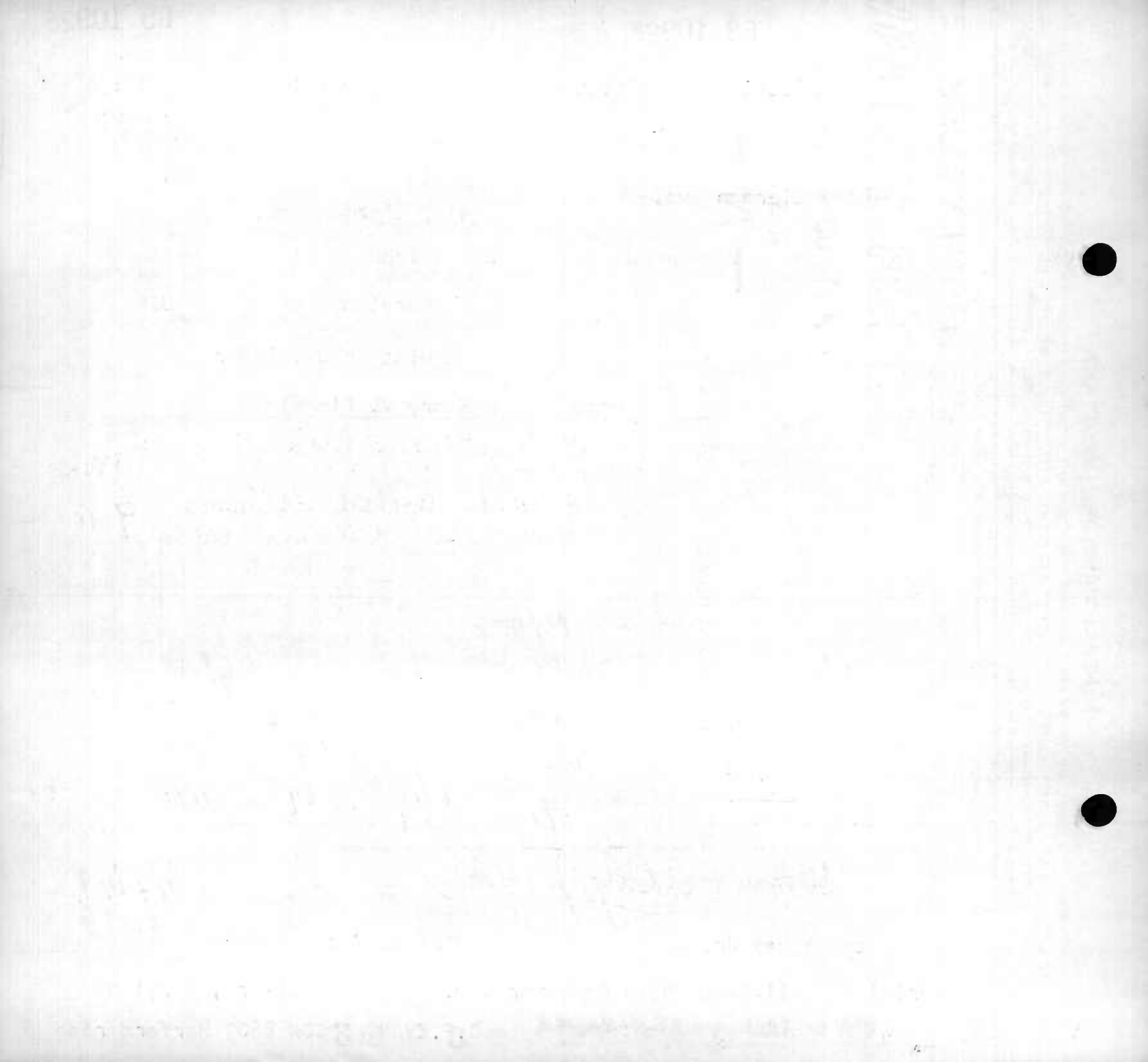
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO. 69 10928

|  |         |  |                          |   |   |
|--|---------|--|--------------------------|---|---|
| BIRTH NO.  |         | 1. NAME OF DECEASED<br>(Type or Print)   |                          | 2. DATE AND HOUR OF DEATH   |   |
|  |         | MOLLIE A DIEGELMAN   |                          | Nov 1 1969 10:30 P.M.   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |         |  |                          | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE B. COUNTY         |   |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |         |  |                          | Md. 2731  |   |
| 00 4127 Eierman Ave,   |         |  |                          | C. CITY OR TOWN D. INSIDE CITY LIMITS?<br>Balto YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
|  |         |  |                          | E. STREET AND NUMBER<br>4127 Eierman ave.   |   |
| 5. SEX   | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH         | 9. AGE (In years last birthday)   | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| F  | W       |  | Nov 1 1888               | 81  |   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |         | 10B. KIND OF BUSINESS OR INDUSTRY  |                          | 11. BIRTHPLACE (State or foreign country)   |   |
| At home  |         |  |                          | Maryland  |   |
| 13. FATHER'S NAME  |         |  | 14. MOTHER'S MAIDEN NAME |   |   |
| Henry Reitze   |         |  | Louise Schuessleder      |   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |         | 16. SOCIAL SECURITY NO.  |                          | 17. INFORMANT ADDRESS   |   |
| No   |         | None   |                          | Henry V. Diegelman  |   |
| 18. 57471<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  |         | CAUSE OF DEATH<br>Cholecystitis = Cholelithiasis<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>A.S.H.D. Cerebral Ischemia<br>(B) Generalized arteriosclerosis<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____ |                          |   |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 WKS + 9 MOS +  |                          |   |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br>II N/A   |         |  |                          |   |   |
| 19A. DATE OF OPERATION   |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                          | 20A. AUTOPSY? (Yes or No)   |   |
| N/A  |         | N/A  |                          | NO  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                          | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |
| N/A  |         | N/A  |                          | N/A   |   |
| 21D. TIME OF INJURY (APPROX.)  |         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Home <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                          | 21F. HOW DID INJURY OCCUR?  |   |
| N/A  |         | N/A  |                          | N/A   |   |
| 22. I certify that (I) (this hospital) attended the deceased from 11/1 to 11/1 1969, that (I) (we) last saw the deceased alive on 11/1 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |         |  |                          |   |   |
| 23A. SIGNATURE<br>Uthman Ray Jr.   |         |  |                          | 23B. DATE SIGNED<br>11/4/69   |   |
| 23C. PHYSICIAN'S NAME (Type)<br>Uthman Ray Jr.   |         |  |                          | 23D. ADDRESS<br>2225 W. North avenue 21216  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |         | 24B. DATE  |                          | 24C. NAME OF CEMETERY or CREMATORY  |   |
| Burial   |         | 11-5-69  |                          | Holy Redeemer Cem.  |   |
| 24D. LOCATION (City, town, or county) (State)  |         | Baltimore, Maryland  |                          |   |   |
| 25A. DATE REC'D BY HEALTH DEPT.  |         | 25B. NAME OF REGISTRAR   |                          | 25C. FUNERAL DIRECTOR ADDRESS   |   |
| NOV 6 1969   |         | Robert E. Taylor, M.D.   |                          | C. F. EVANS & SON 8802 Harford road   |   |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| R-240 1   |  | BALTIMORE CITY HEALTH DEPARTMENT<br>69 10929 CERTIFICATE OF DEATH  |  | REG. NO. 69 10929   |
|---|--|--|--|---|
| BIRTH NO.   |  | 1. NAME OF DECEASED<br>(Type or Print) MYRTLE M. RUSSELL   |  | 2. DATE AND HOUR OF DEATH<br>11/2/69 12 15 P.M.   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE BALTIMORE, MARYLAND. 1348<br>B. COUNTY |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>44 Union Memorial Hospital  |  | C. CITY OR TOWN<br>BALTIMORE   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |
| 5. SEX<br>F   |  | 6. RACE<br>W   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife  |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 8. DATE OF BIRTH<br>03/12/91  |
| 13. FATHER'S NAME<br>JAMES M. SMITHE  |  | 14. MOTHER'S MAIDEN NAME<br><del>UNKNOWN</del> Eleanora Frazer   |  | 9. AGE (In years last birthday)<br>78   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO.<br>216-10-02410  |  | 11. BIRTHPLACE (State or foreign country)<br>MARYLAND   |
| 17. INFORMANT<br>MRS. ELEANORA SELLERS  |  | 12. CITIZEN OF WHAT COUNTRY?   |  |   |
| 18. 437.9 I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>Respiratory failure  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
|   |  | (B) DUE TO, OR AS A CONSEQUENCE OF:<br>Pulmonary edema.  |  |   |
|   |  | (C) Cerebral arteriosclerosis and Parkinsonism.  |  |   |
| MEDICAL CERTIFICATION   |  | 20A. AUTOPSY? (Yes or No)<br>NO  |  |   |
| 19A. DATE OF OPERATION<br>0   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX.)  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                |  | 21F. HOW DID INJURY OCCUR?  |
| 22. I certify that (I) (this hospital) attended the deceased from 10/30 to 11/2/69 that (I) (we) last saw the deceased alive on 11/1/69 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.   |  |  |  |   |
| 23A. SIGNATURE<br>Anne L. Leddy M.D.  |  | 23B. DATE SIGNED<br>11/2/69  |  | 23C. PHYSICIAN'S NAME (Type)<br>DR ANNE L LEDDY   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |  | 24B. DATE<br>11-5-69   |  | 24C. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cemetery  |
| 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Maryland  |  | 25A. DATE RECEIVED BY HEALTH DEPT.<br>NOV 6 1969   |  |   |
| 25B. NAME OF REGISTRAR<br>Robert E. Taber, M.D.   |  | 25C. FUNERAL DIRECTOR<br>John C. Miller Inc-415 Belair Rd.-21206   |  |   |

THE NEW YORK PUBLIC LIBRARY

ASTOR LENOX TILDEN FOUNDATION

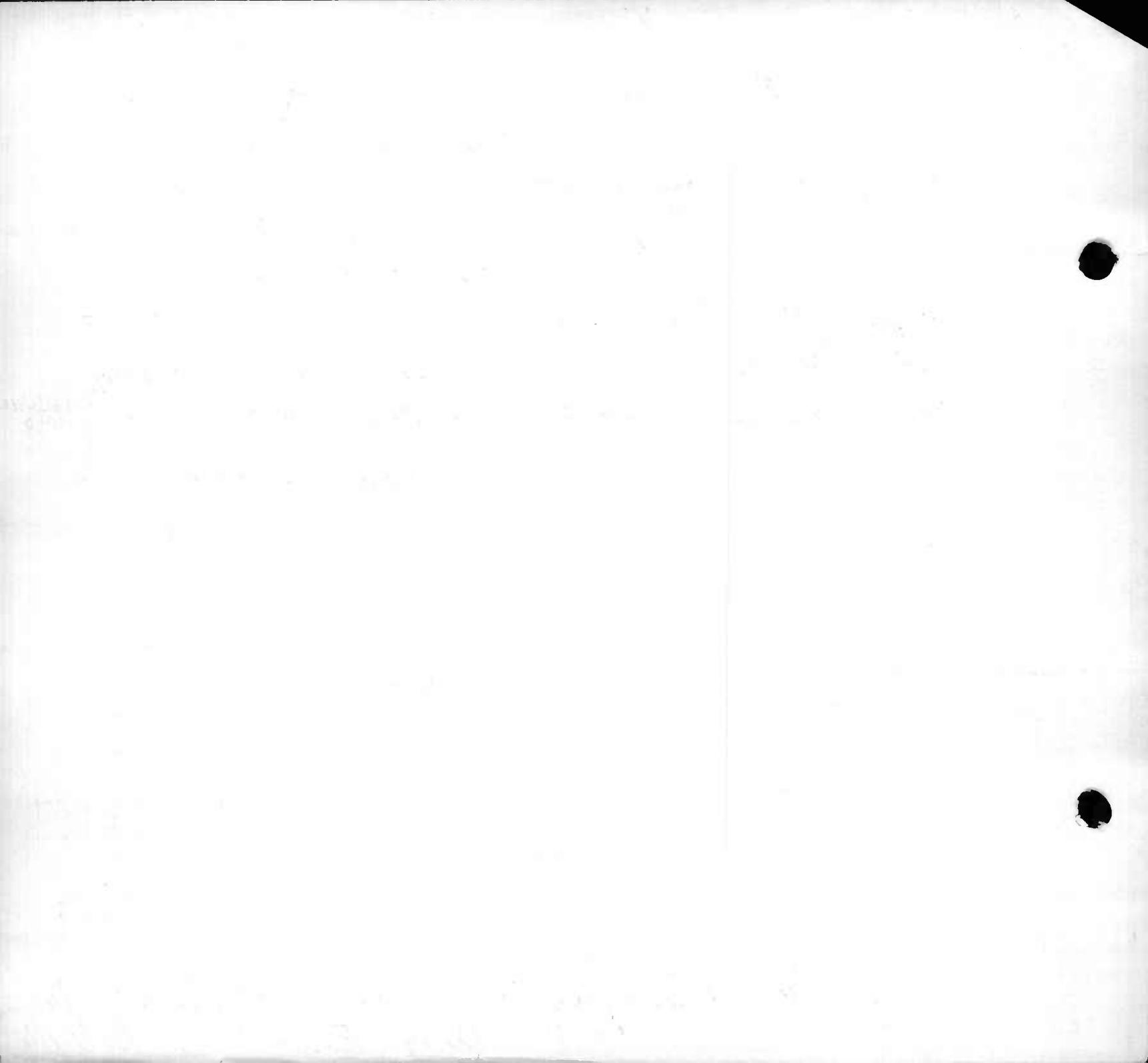
1215 5th Ave. New York 10029

ALFRED L. FREDERICKS, JR. 1910-1978

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

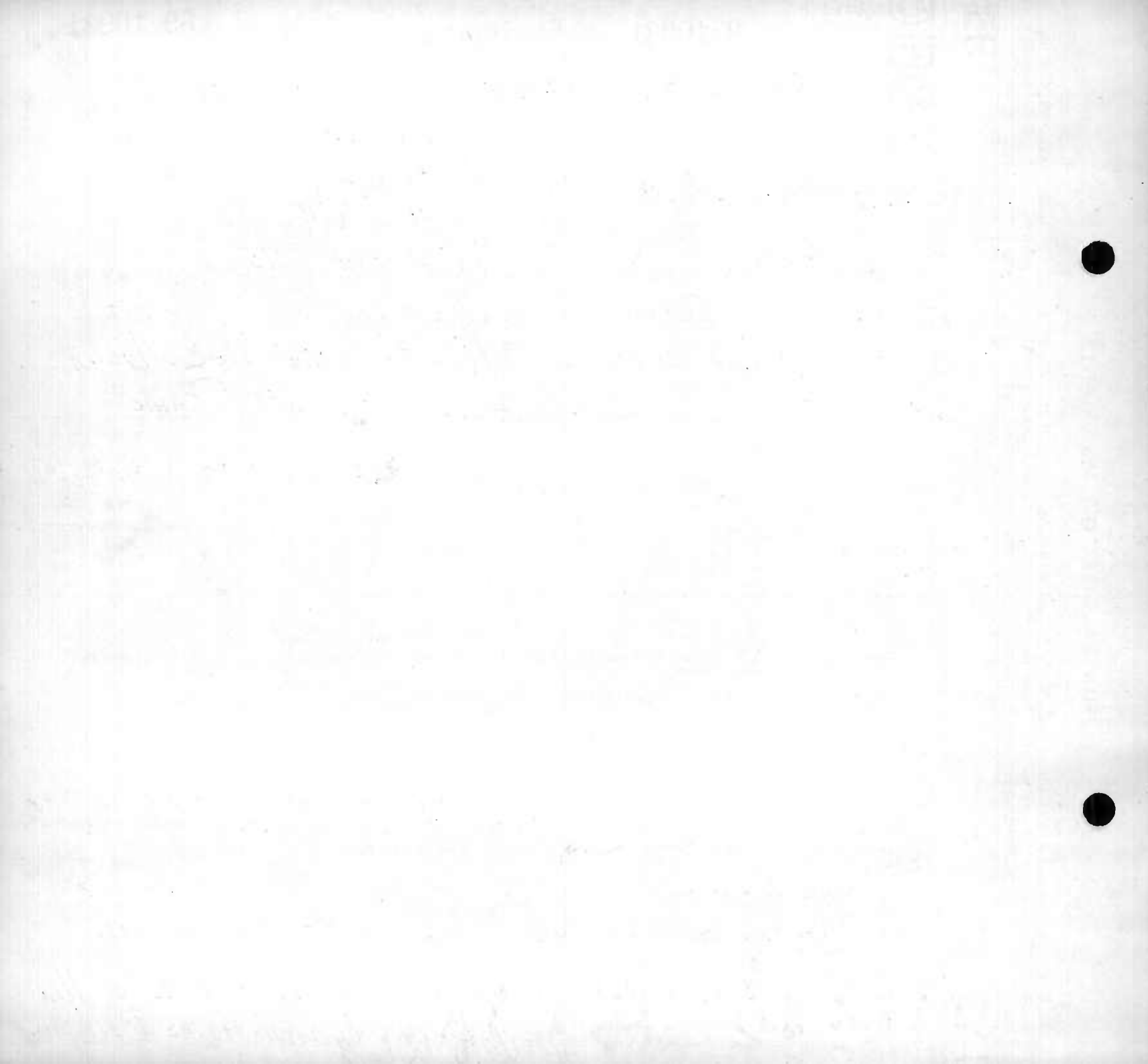
| BALTIMORE CITY HEALTH DEPARTMENT   |  |   |  | REG. NO. <b>69 10930</b>   |  |
|--|--|---|--|--|--|
| BIRTH NO. <b>69 10930</b>  |  |   |  | CERTIFICATE OF DEATH   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Allen E Becker</b>   |  | 2. DATE AND HOUR OF DEATH<br><b>11-3-69 10<sup>00</sup> P.M.</b>  |  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br><b>Maryland General Hospital<br/>48</b>  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD</b> B. COUNTY <b>2605</b> |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Maryland General Hospital</b>   |  | C. CITY OR TOWN<br><b>Baltimore</b>   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 5. SEX <b>M</b>  |  | 6. RACE <b>W</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Shipping Clerk</b>   |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Warehouse</b>   |  | 8. DATE OF BIRTH<br><b>April 14 1913</b>   |  |
| 13. FATHER'S NAME<br><b>Otto Becker</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Annie Mary Hepding</b>   |  | 9. AGE (In years last birthday) <b>56</b>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes WW II</b>   |  | 16. SOCIAL SECURITY NO.<br><b>214 03 3219</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>MD</b>   |  |
| 18. <b>199-0 I</b>   |  | CAUSE OF DEATH  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Carcinomatosis</b>   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |  | (B) DUE TO, OR AS A CONSEQUENCE OF:   |  |  |  |
| (C) DUE TO, OR AS A CONSEQUENCE OF:  |  |   |  |  |  |
| II   |  |   |  |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |   |  |  |  |
| 19A. DATE OF OPERATION<br><b>0</b>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                         |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10/20</b> 19 <b>69</b> to <b>11/3</b> 19 <b>69</b> that (I) (we) last saw the deceased alive on <b>10/3</b> 19 <b>69</b> and that (in) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death. |  |   |  |  |  |
| 23A. SIGNATURE<br><b>Michael G. [Signature]</b>  |  |   |  | 23B. DATE SIGNED<br><b>11/3/69</b>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Michael G. [Signature]</b>  |  | 23D. ADDRESS<br><b>FROSTBURG MD</b>   |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>11-7-69</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Dolney Valley Mem.</b>  |  |
| 24D. LOCATION<br><b>Cockeysville, Bt H Co Md</b>   |  | 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 6 1969</b>  |  | 25B. NAME OF REGISTRAR<br><b>Robert E. [Signature]</b>   |  |
| 25C. FUNERAL DIRECTOR<br><b>Bourged Funeral Home</b>   |  | 25D. ADDRESS<br><b>Baltimore</b>  |  |  |  |



FUNERAL DIRECTOR: IMPORTANT

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| BALTIMORE CITY HEALTH DEPARTMENT  |                         |   |   | REG. NO. <b>69 10931</b>  |
|---|-------------------------|---|---|---|
| 69 10931 CERTIFICATE OF DEATH   |                         |   |   |   |
| BIRTH NO.   |                         | 1. NAME OF DECEASED<br>(Type or Print) <b>Bessie Pearl Morrison</b>   |   | 2. DATE AND HOUR OF DEATH<br><b>Oct 30 1969</b>   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                         | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>1306</b>                     |   |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Union Mem Hosp.</b>  |                         | C. CITY OR TOWN<br><b>Baltimore</b>   |   | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| E. STREET AND NUMBER<br><b>3531 Falls Rd</b>  |                         |   |   |   |
| 5. SEX<br><b>Female</b>   | 6. RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Sept 25 1894</b> | 9. AGE (In years last birthday)<br><b>75</b>  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Hostess</b>   |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Funeral Home</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                         |   |   |   |
| 13. FATHER'S NAME<br><b>Howard Abraham Wisner</b>   |                         | 14. MOTHER'S MAIDEN NAME<br><b>Rosetta Ann McCullough</b>   |   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                         | 16. SOCIAL SECURITY NO.<br><b>213309852</b>   |   | 17. INFORMANT<br><b>Muriel V Hunt</b>   |
| 18. <b>180X I</b>   |                         | CAUSE OF DEATH  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Sept. 1968</b>                             |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)   |                         | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF: <b>Carcinoma of cervix</b>   |   |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,  |                         | (B) DUE TO, OR AS A CONSEQUENCE OF:   |   |   |
| (C) _____   |                         |   |   |   |
| II  |                         |   |   |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                         |   |   |   |
| 19A. DATE OF OPERATION  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |
| 21D. TIME OF INJURY (APPROX.)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |   | 21F. HOW DID INJURY OCCUR?  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Sept 9 1968</b> to <b>Oct 30 1969</b> , that (I) (we) last saw the deceased alive on <b>Oct 25 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |   |   |   |
| 23A. SIGNATURE<br><b>Reuben Hoffman</b>   |                         |   |   | 23B. DATE SIGNED<br><b>11-1-69</b>  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>REUBEN HOFFMAN, M.D.</b>   |                         |   |   | 23D. ADDRESS<br><b>846 W. 36th St., Baltimore, MD.</b>  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 24B. DATE<br><b>11-3-69</b>   |   | 24C. NAME OF CEMETERY, CREMATORY<br><b>Druid Ridge Cem</b>                                    |
| 24D. LOCATION<br><b>Pikesville, Balto Co Md</b>   |                         | 24E. (City, town, or county) (State)  |   |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 6 1969</b>  |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Talley, Jr.</b>  |   | 25C. FUNERAL DIRECTOR<br><b>Burgess Funeral Home Balto Md</b>                                 |
| 25D. ADDRESS  |                         |   |   |   |



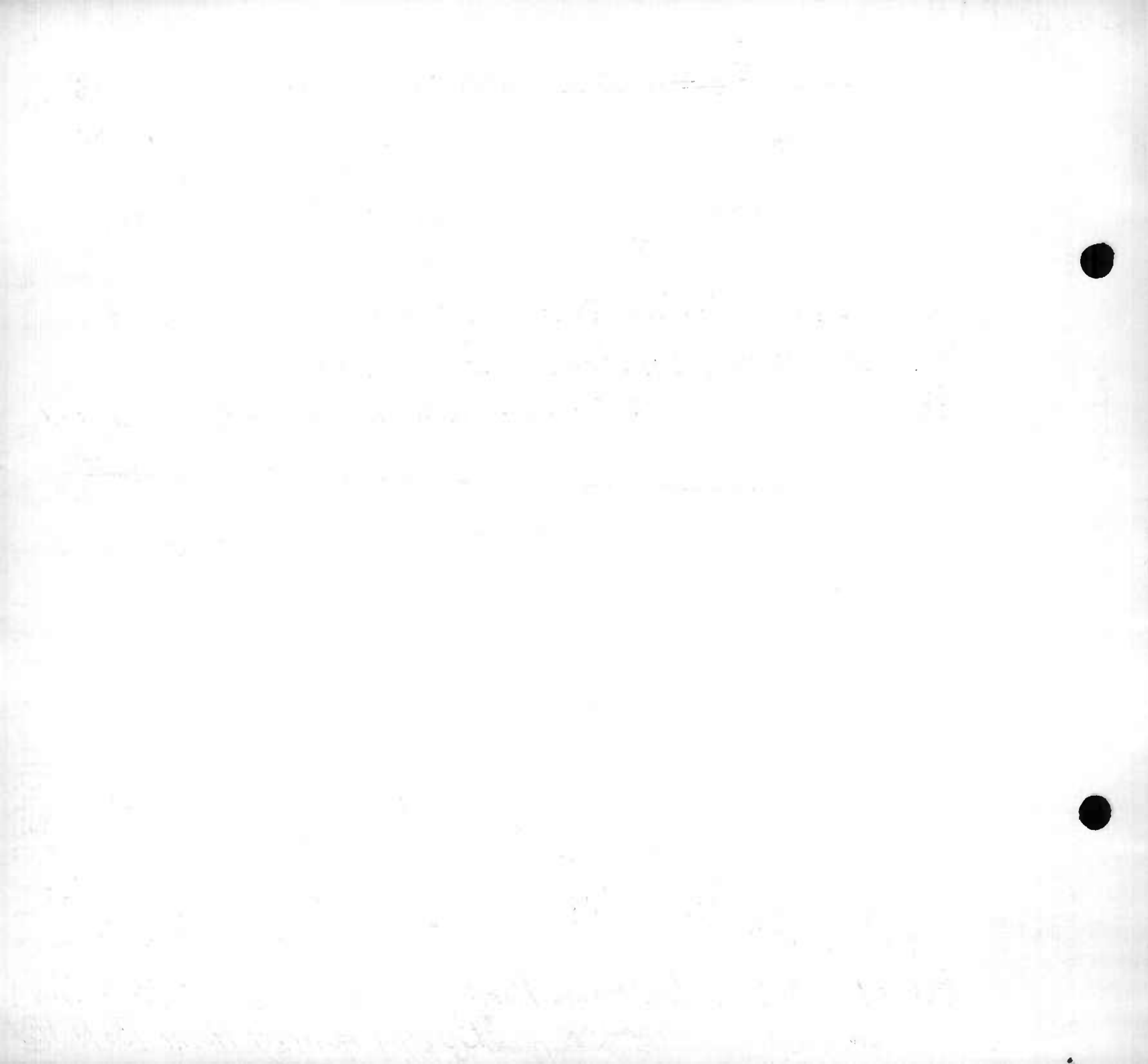


# FUNERAL DIRECTOR: IMPORTANT

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5-160

| BALTIMORE CITY HEALTH DEPARTMENT  |            |   |                           | REG. NO. 69 10932  |  |
|---|------------|---|---------------------------|--|--|
| BIRTH NO. 69 10932  |            | CERTIFICATE OF DEATH  |                           | REG. NO. 69 10932  |  |
| 1. NAME OF DECEASED<br>(Type or Print) CHARLES E. <del>SHAFER</del> SHAFER  |            | 2. DATE AND HOUR OF DEATH<br>11/2/69 3:08 P.M.  |                           |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>SINAI Hosp.   |            | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE MARYLAND B. COUNTY 1306<br>C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER 3509 Roland Rd. |                           |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |            |   |                           |  |  |
| 5. SEX M  | 6. RACE W. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH 11/25/05 | 9. AGE (In years last birthday) 63                                       | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman   |            | 10B. KIND OF BUSINESS OR INDUSTRY Police Dept   |                           | 11. BIRTHPLACE (State or foreign country) Maryland                       |  |
| 13. FATHER'S NAME Theodore Henry Shaffer  |            | 14. MOTHER'S MAIDEN NAME Grace Bull   |                           | 12. CITIZEN OF WHAT COUNTRY USA  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes or no) (If yes, give war or dates of service) No  |            | 16. SOCIAL SECURITY NO. 215 401694  |                           | 17. INFORMANT Ruth Shaffer 3509 Roland Ave                               |  |
| 18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |            | CAUSE OF DEATH  |                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  |            | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary edema   |                           | 5 days   |  |
| ANTECEDENT CAUSES   |            | (B) acute myocardial infarct  |                           |  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |            | (C)   |                           |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |            |   |                           |  |  |
| 19A. DATE OF OPERATION 11/2/69  |            | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                           | 20A. AUTOPSY? (Yes or No) Yes  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)   |            | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                           | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME OF INJURY (Approx.)   |            | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                           | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (1) (this hospital) attended the deceased from 11/3/69 to 11/3/69 that (1) (we) lost saw the deceased alive on 11/3/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death. |            |   |                           |  |  |
| 23A. SIGNATURE Dr. M. Levin M.D.  |            | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>   |                           | 23B. DATE SIGNED 11/3/69   |  |
| 23C. PHYSICIAN'S NAME (Type) M. LEVIN M.D.  |            | 23D. ADDRESS Sinai Hosp. Baltimore  |                           |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial   |            | 24B. DATE 11-6-69   |                           | 24C. NAME OF CEMETERY OR CREMATORY Lorraine Park                         |  |
| 24D. LOCATION Woodlawn Baltimore Md   |            |   |                           |  |  |
| 25A. DATE REC'D BY HEALTH DEPT. NOV 6 1969  |            | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D.   |                           | 25C. FUNERAL DIRECTOR Burger Funeral Home Baltimore                      |  |
|   |            |   |                           | ADDRESS  |  |



69 10933

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 10933

REG. NO.

BIRTH NO.

|   |                           |   |  |   |  |   |  |
|---|---------------------------|---|--|---|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>Gerald Burnside</b>  |                           |   |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month Day Year Hour<br><b>11 3 69 9:50 p.m.</b> |  |   |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>40 St. Agnes Hospital</b>  |                           |   |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>11 3 69 9:50 p.m.</b>  |  |   |  |
| 5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>2037</b>   |                           |   |  | C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                         |  |   |  |
| 6. SEX<br><b>male</b>   | 7. RACE<br><b>colored</b> | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | E. STREET AND NUMBER<br><b>401 Gwynn Ave.</b>   |  |   |  |
| 9. DATE OF BIRTH<br><b>9-8-1918</b>   |                           | 10. AGE (In years lost birthday)<br><b>51</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>South Carolina</b>  |  |   |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>   |                           | 14B. KIND OF BUSINESS OR INDUSTRY<br><b>American S. Radiato Co.</b>   |  | 13. FATHER'S NAME<br><b>Guy Burnside</b>  |  |   |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                           | 17. SOCIAL SECURITY NO.<br><b>220-05-7947</b>   |  | 15. MOTHER'S MAIDEN NAME<br><b>Susie Henderson</b>  |  |   |  |
| 18. INFORMANT<br><b>Mrs. Geraldine Harrison</b>   |                           |   |  | ADDRESS<br><b>3404 Alto Road</b>  |  |   |  |
| 19. CAUSE OF DEATH<br><b>412.4</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>Arteriosclerotic cardiovascular disease</b><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) DUE TO, OR AS A CONSEQUENCE OF:   |                           |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                           |   |  |   |  |   |  |
| 20A. DATE OF OPERATION  |                           | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 21. AUTOPSY? (Yes or No)<br><b>no</b>                                     |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                           | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?  |  |   |  |
| 22D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)  |                           | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 22F. HOW DID INJURY OCCUR?  |  |   |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Werner U. Spitz</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>11/4/69</b> |                           |   |  |   |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                           | 24B. DATE<br><b>11-7-69</b>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Arbutus Memorial Park</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore Co. Md.</b> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 6 1969</b>  |                           | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>   |  | 25C. FUNERAL DIRECTOR ADDRESS<br><b>Nutter Funeral Home 3035 W. North Ave</b>   |  |   |  |

83 1033

83 1002

MAILBOX FORGIE  
P.O. BOX 117111

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

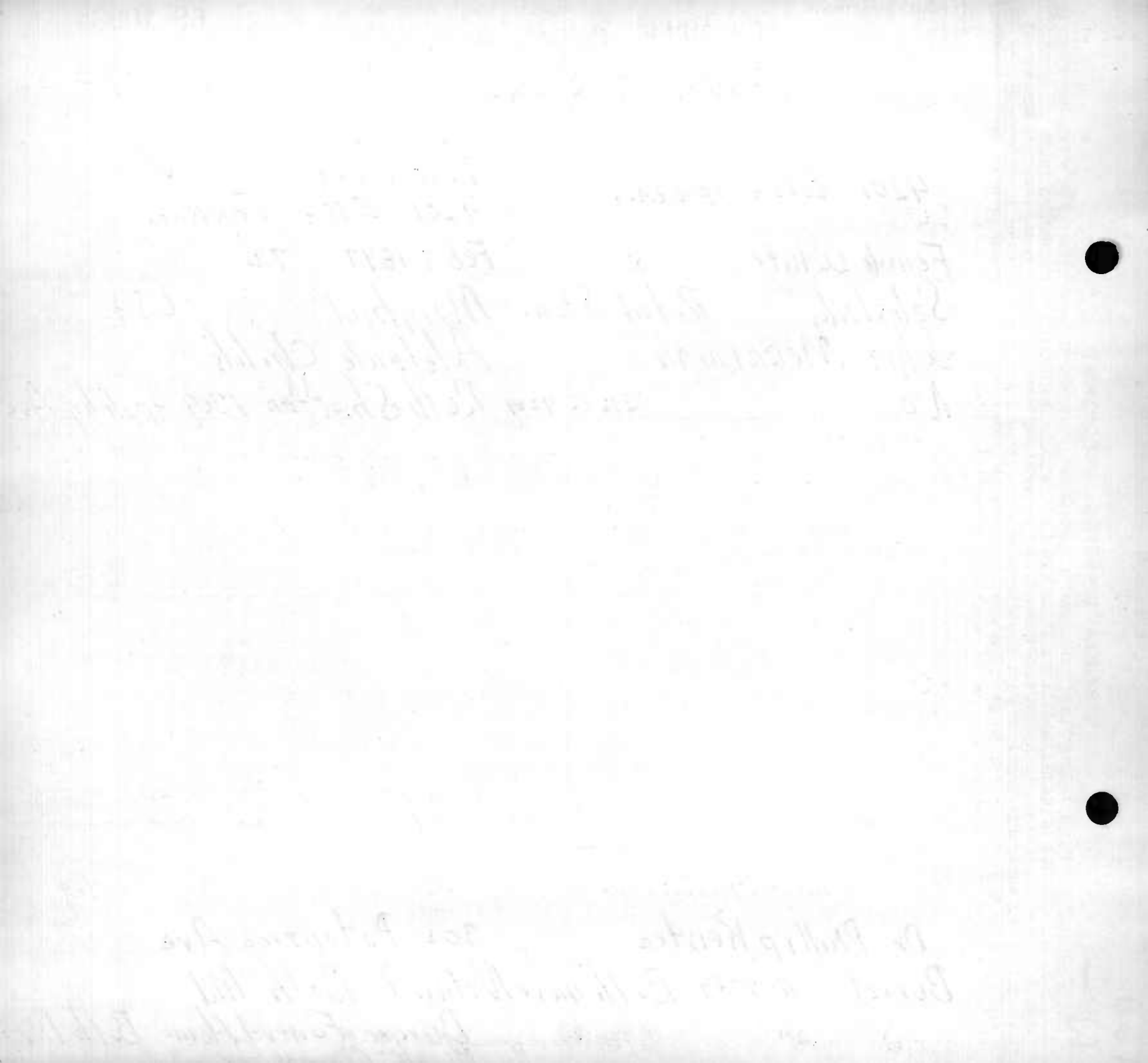
| BALTIMORE CITY HEALTH DEPARTMENT   |                                |   |  | REG. NO. <b>69 10934</b>   |
|--|--------------------------------|---|--|--|
| <b>BIRTH NO.</b><br><b>1. NAME OF DECEASED</b><br>(Type or Print) <b>FRANK A. SIMMONS</b>  |                                | <b>2. DATE AND HOUR OF DEATH</b><br><b>9:50 am 11/4/69</b>  |  |  |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><br><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location)<br><b>46 Lutheran Hospital</b><br><b>730 Ashburton St. Baltimore</b><br><b>21216</b>   |                                | <b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)<br><b>A. STATE</b> <b>Maryland</b> <b>B. COUNTY</b> <b>1403</b><br><b>C. CITY OR TOWN</b> <b>Baltimore</b> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br><b>E. STREET AND NUMBER</b><br><b>1932 Druid Hill Avenue</b> |  |  |
| <b>5. SEX</b><br><b>M</b>  | <b>6. RACE</b><br><b>Negro</b> | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>  | <b>8. DATE OF BIRTH</b><br><b>11-14-82</b> | <b>9. AGE</b> (In years last birthday) <b>86</b><br><b>If Under 1 Yr. Months: Days</b> <b>If Under 24 Hrs. Hours: Min.</b> |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Inter. &amp; Exter. Decorator</b>   |                                | <b>10B. KIND OF BUSINESS OR INDUSTRY</b><br>  |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>Maryland</b>  |
| <b>13. FATHER'S NAME</b><br><b>Joseph Simmons</b>  |                                | <b>14. MOTHER'S MAIDEN NAME</b><br><b>?</b>   |  |  |
| <b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                                | <b>16. SOCIAL SECURITY NO.</b><br><b>218-32-0694</b>  |  | <b>17. INFORMANT</b> <b>Kathleen Simmons</b> <b>ADDRESS</b><br><b>Mrs. Kathleen Simmons 1932 Druid Hill Ave.</b>           |
| <b>18. CAUSE OF DEATH</b>  |                                |   |  |  |
| <b>1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br><b>2. ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br><b>3. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b> |                                |   |  |  |
| <b>(A) IMMEDIATE CAUSE</b> <b>Haematemesis</b><br><b>DUE TO, OR AS A CONSEQUENCE OF:</b><br><br><b>(B) Ca. Head of the Pancreas.</b><br><b>DUE TO, OR AS A CONSEQUENCE OF:</b><br><br><b>(C)</b>   |                                |   |  |  |
| <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>  |                                |   |  |  |
| <b>MEDICAL CERTIFICATION</b>   |                                |   |  |  |
| <b>19A. DATE OF OPERATION</b><br><b>0</b>  |                                | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>   |  | <b>20A. AUTOPSY? (Yes or No)</b><br><b>No</b>  |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>  |                                | <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)  |
| <b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)   |                                | <b>21E. INJURY OCCURRED</b><br><b>While At Work</b> <input type="checkbox"/> <b>Not While At Work</b> <input type="checkbox"/>  |  | <b>21F. HOW DID INJURY OCCUR?</b>  |
| <b>22. I certify that (I) (this hospital) attended the deceased from</b> <b>10/28/1969</b> <b>to</b> <b>11/4/1969</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>2:50 am 11/4/1969</b> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>   |                                |   |  |  |
| <b>23A. SIGNATURE</b><br><b>Pratima Khasnagar</b>  |                                |   |  | <b>23B. DATE SIGNED</b><br><b>11/4/69</b>  |
| <b>23C. PHYSICIAN'S NAME (Type)</b> <b>PRATIMA KHASNAGIR</b>   |                                | <b>23D. ADDRESS</b><br><b>Lutheran Hospital</b>   |  |  |
| <b>24A. BURIAL CREMATION, REMOVAL (Specify)</b><br><b>Burial</b>   |                                | <b>24B. DATE</b><br><b>11-7-69</b>  |  | <b>24C. NAME OF CEMETERY or CREMATORY</b><br><b>Cathedral Cemetery</b>   |
| <b>24D. LOCATION</b> (City, town, or county) (State)<br><b>Baltimore Md</b>  |                                |   |  |  |
| <b>25A. DATE REC'D BY HEALTH DEPT.</b><br><b>NOV 6 1969</b>  |                                | <b>25B. NAME OF REGISTRAR</b><br><b>Robert E. Taylor, M.D.</b>  |  | <b>25C. FUNERAL DIRECTOR</b> <b>ADDRESS</b><br><b>Nutter Funeral Home 3035 W. North Ave</b>                                |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |  |   |  | REG. NO. <b>69 10935</b>   |
|---|--|---|--|--|
| 69 10935  |  | CERTIFICATE OF DEATH  |  |  |
| BIRTH NO. _____   |  |   |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>ANNA R. Stone</b>   |  | 2. DATE AND HOUR OF DEATH<br><b>Nov 2 1969 9<sup>00</sup> A.M.</b>  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>                      |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>4201 Elsa Terrace</b>  |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |  | C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                              |
| 5. SEX <b>Female</b>  |  | 6. RACE <b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH <b>Feb 3 1897</b>  |  | 9. AGE (In years last birthday) <b>72</b>   |  | If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min. _____  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saleslady</b>  |  | 10B. KIND OF BUSINESS OR INDUSTRY <b>Retail Store</b>   |  | 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |
| 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 13. FATHER'S NAME <b>John Merriman</b>  |  |  |
| 14. MOTHER'S MAIDEN NAME <b>Adelaide Childs</b>   |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>  |  |  |
| 16. SOCIAL SECURITY NO. <b>216 12 9269</b>  |  | 17. INFORMANT <b>Ruth Shaffer</b> ADDRESS <b>1309 Appleby Ave</b>   |  |  |
| 18. <b>412.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>coronary artery disease</b>   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____  |  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>hypertension</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF: _____<br>(C) DUE TO, OR AS A CONSEQUENCE OF: _____ |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). _____  |  |   |  |  |
| 19A. DATE OF OPERATION <b>0</b>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No) _____  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR? _____   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Oct 1 1960</b> to <b>Nov 2 1969</b> , that (I) <del>was</del> last saw the deceased alive on <b>11/1 1969</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> <b>did</b> (did not) view the body after death. |  |   |  |  |
| 23A. SIGNATURE <b>Phillip Keister M.D.</b>  |  | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>                                   |  | 23B. DATE SIGNED <b>11/5/69</b>  |
| 23C. PHYSICIAN'S NAME (Type) <b>Dr. Phillip Keister</b>   |  | 23D. ADDRESS <b>302 Patapsco Ave</b>  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 24B. DATE <b>11-5-69</b>  |  | 24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National</b>   |
| 24D. LOCATION (City, town, or county) <b>Baltimore Md</b>   |  | 24E. STATE <b>Md</b>  |  |  |
| 25A. DATE REC'D BY HEALTH DEPT. <b>NOV 6 1969</b>   |  | 25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>  |  | 25C. FUNERAL DIRECTOR <b>Burgess Funeral Home</b> ADDRESS <b>Baltimore Md</b>  |





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 10936

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 10936

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mary E Noland

2. DATE AND HOUR OF DEATH

Nov 2 1969 755 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)Ardleigh Nursing Home  
90 2095 Rockrose Ave

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

Baltimore  
Maryland  
3730 Elm Ave

5. SEX

6. RACE

Female White

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

July 28 1895 - 74

9. AGE (In years  
last birthday)If Under 1 Yr.  
Months DaysIf Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Alf

Ruby

14. MOTHER'S MAIDEN NAME

Susie Chambers

15. Was Deceased Ever in U. S. Armed Forces?

(Yes or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

-

17. INFORMANT

Edward L Noland 5422 Montbell

ADDRESS

18.

412.3

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

Generalized Arterio Sclerosis

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

10 yrs.

2 yrs.

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

None

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this ~~person~~) attended the deceased from Feb. 15 1968 to Nov. 2 1969.  
that (I) (we) last saw the deceased alive on Oct. 17 1969 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

Earl L. Chambers M.D.

DEGREE

Attending  
Phys. ☒Med.  
Director ☐Staff  
Phys. ☐

23B. DATE SIGNED

11/5/69

23C. PHYSICIAN'S  
NAME (Type)

Dr. Earl Chambers

DEGREE

23D. ADDRESS

100 W Cold Spring Lane

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

11-5-69

24C. NAME OF CEMETERY or CREMATORY

Lorraine Park

24D. LOCATION

Woodlawn, Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.

NOV 6 1969

25B. NAME OF REGISTRAR

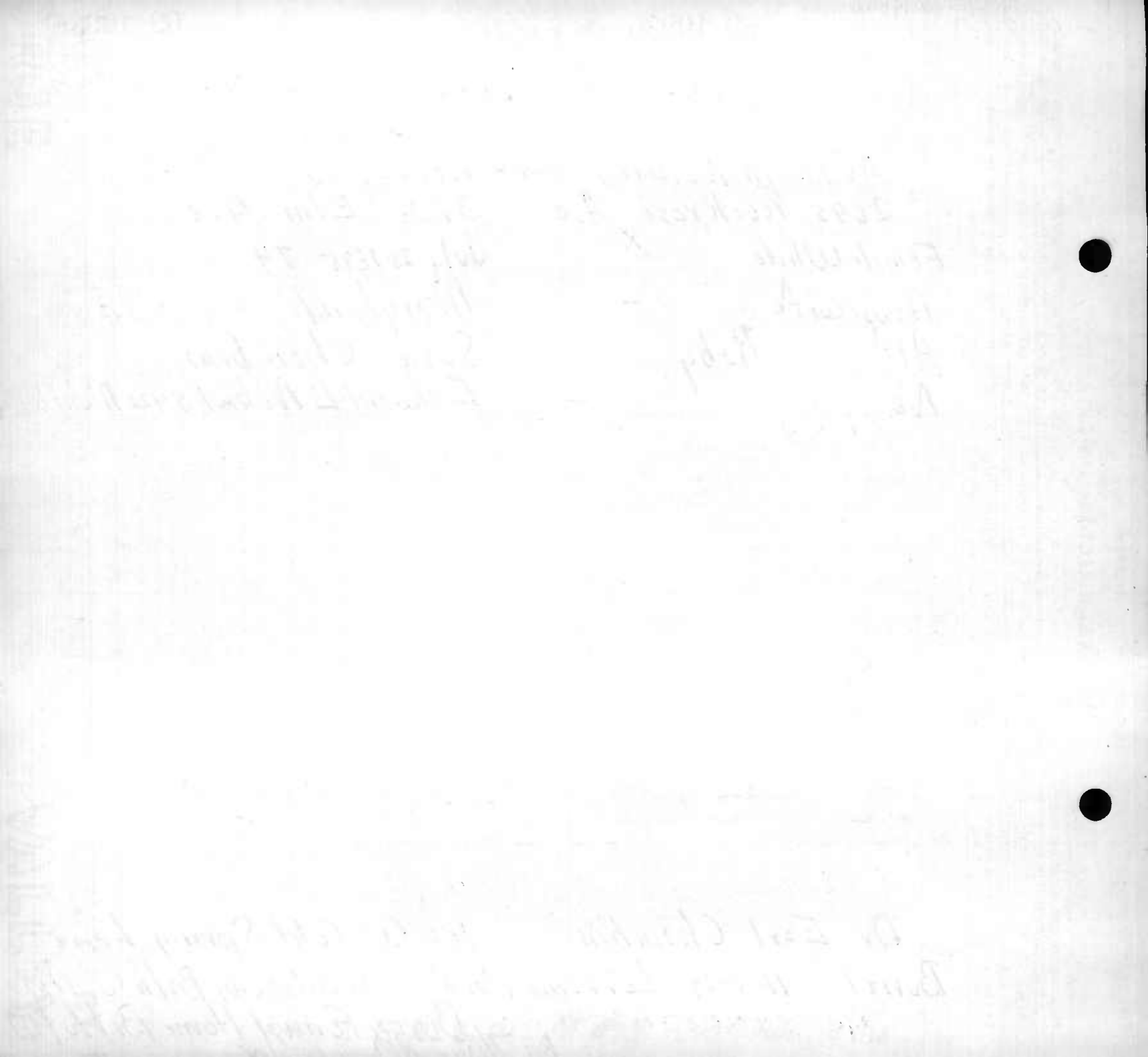
Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Burgess Funeral Home Baltimore Md

ADDRESS

Burgess Funeral Home Baltimore Md



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 10937

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 10937

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| BIRTH NO.   |  | 1. NAME OF DECEASED<br>(Type or Print) <i>Katherine E Arthur</i>  |  | 2. DATE AND HOUR OF DEATH<br><i>Nov 1 1969 7<sup>30</sup> A.M.</i>  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY <i>2755</i> |  | C. CITY OR TOWN <i>Baltimore</i>  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>The Wesley Home</i>  |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><i>2211 W Rogers Ave</i>  |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 5. SEX <i>Female</i>  |  | 6. RACE <i>White</i>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH <i>Sept 2 1892</i>   |  | 9. AGE (In years last birthday) <i>77</i>   |  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>HOUSEWIFE</i>   |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>AT HOME</i>   |  | 11. BIRTHPLACE (State or foreign country)<br><i>Md</i>  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 13. FATHER'S NAME<br><i>August BORNEMAN</i>   |  | 14. MOTHER'S MAIDEN NAME<br><i>Martha Brown</i>   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>No</i>   |  | 16. SOCIAL SECURITY NO.<br><i>WA 868482</i>   |  | 17. INFORMANT<br><i>The Wesley Home</i>   |  |
| 18. <i>412.41</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><i>Arteriosclerotic cardiovascular disease</i>   |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><i>disease</i>   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  | (B) DUE TO, OR AS A CONSEQUENCE OF:   |  | (C) DUE TO, OR AS A CONSEQUENCE OF:   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |   |  |   |  |
| 19A. DATE OF OPERATION<br><i>0</i>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><i>No</i>  |  |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                       |  |   |  |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |   |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)   |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                               |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>27 April 1969</i> to <i>1 November 1969</i> , that (I) (we) last saw the deceased alive on <i>30 September 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |   |  |   |  |
| 23A. SIGNATURE<br><i>John W. Barnaby MD</i>   |  | 23B. PHYSICIAN'S NAME (Type)<br><i>JOHN W. BARNABY</i>  |  | 23C. ADDRESS<br><i>1652 E. Eubank Ave Baltimore MD</i>  |  |
| 23D. DATE SIGNED<br><i>4 Nov 69</i>   |  | 23E. SIGNATURE OF REGISTRAR<br><i>Robert E. Taylor MD</i>   |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Buried</i>   |  | 24B. DATE<br><i>11-4-69</i>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><i>New Cathedral</i>  |  |
| 24D. LOCATION (City, town, or county) (State)<br><i>B21 to Md</i>   |  | 24E. FUNERAL DIRECTOR<br><i>Burgess Funeral Home Baltimore</i>  |  |   |  |
| 24F. DATE REC'D BY HEALTH DEPT.<br><i>NOV 6 1969</i>  |  | 24G. ADDRESS<br><i>Burgess Funeral Home Baltimore</i>   |  |   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 10938

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 69 10938

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| BIRTH NO.  |  | 1. NAME OF DECEASED<br>(Type or Print) <b>CZINCILIA FRANCES MARY</b>  |  | 2. DATE AND HOUR OF DEATH<br><b>11/01/69</b> <b>8:15AM</b> M.  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>1509</b>                   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>40</b>  |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>ST AGNES HOSPITAL<br/>CATON &amp; WILKENS AVENUE<br/>BALTIMORE, MARYLAND 21229</b> |  | C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                              |  |
| 5. SEX <b>FEMALE</b>   |  | 6. RACE <b>WHITE</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>MACHINE OPERATOR</b> |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Paul Distillery</b>   |  | 8. DATE OF BIRTH <b>06/15/99</b> 9. AGE (In years last birthday) <b>70</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>VIRGINIA</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  |  |  |  |
| 13. FATHER'S NAME<br><b>MICHAEL O'NEIL</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>FRANCES MARSH</b>  |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service]               |  | 16. SOCIAL SECURITY NO.<br><b>219 10 3387</b>   |  | 17. INFORMANT ADDRESS<br><b>ST AGNES HOSP CATON &amp; WILKENS AVE</b>  |  |

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 18. <b>250.9 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <b>Atherosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <b>Diabetes mellitus</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |   |  |  |  |
| 19A. DATE OF OPERATION<br><b>0</b>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>                                   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> Notify medical examiner  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (H) (this hospital) attended the deceased from <b>10/17/69</b> 19 to <b>11/01/69</b> 19 that (X) (we) last saw the deceased alive on <b>11/01/69</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.                    |  |   |  |  |  |
| 23A. SIGNATURE<br>   |  |   |  | 23B. DATE SIGNED<br><b>11/01/69</b>                                      |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>SALVADOR QUIROZ M D</b>   |  | 23D. ADDRESS<br><b>ST AGNES HOSP CATON &amp; WILKENS AVE 21229</b>  |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>Nov. 4, 1969</b>  |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Lorraine Park Cemetery</b>      |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>  |  | 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 6 1969</b>  |  |  |  |
| 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>  |  | 25C. FUNERAL DIRECTOR<br><b>G. Truman Schwab</b>  |  |  |  |
| ADDRESS<br><b>3512 Frederick ave., Baltimore, Md. 21229</b>  |  |   |  |  |  |

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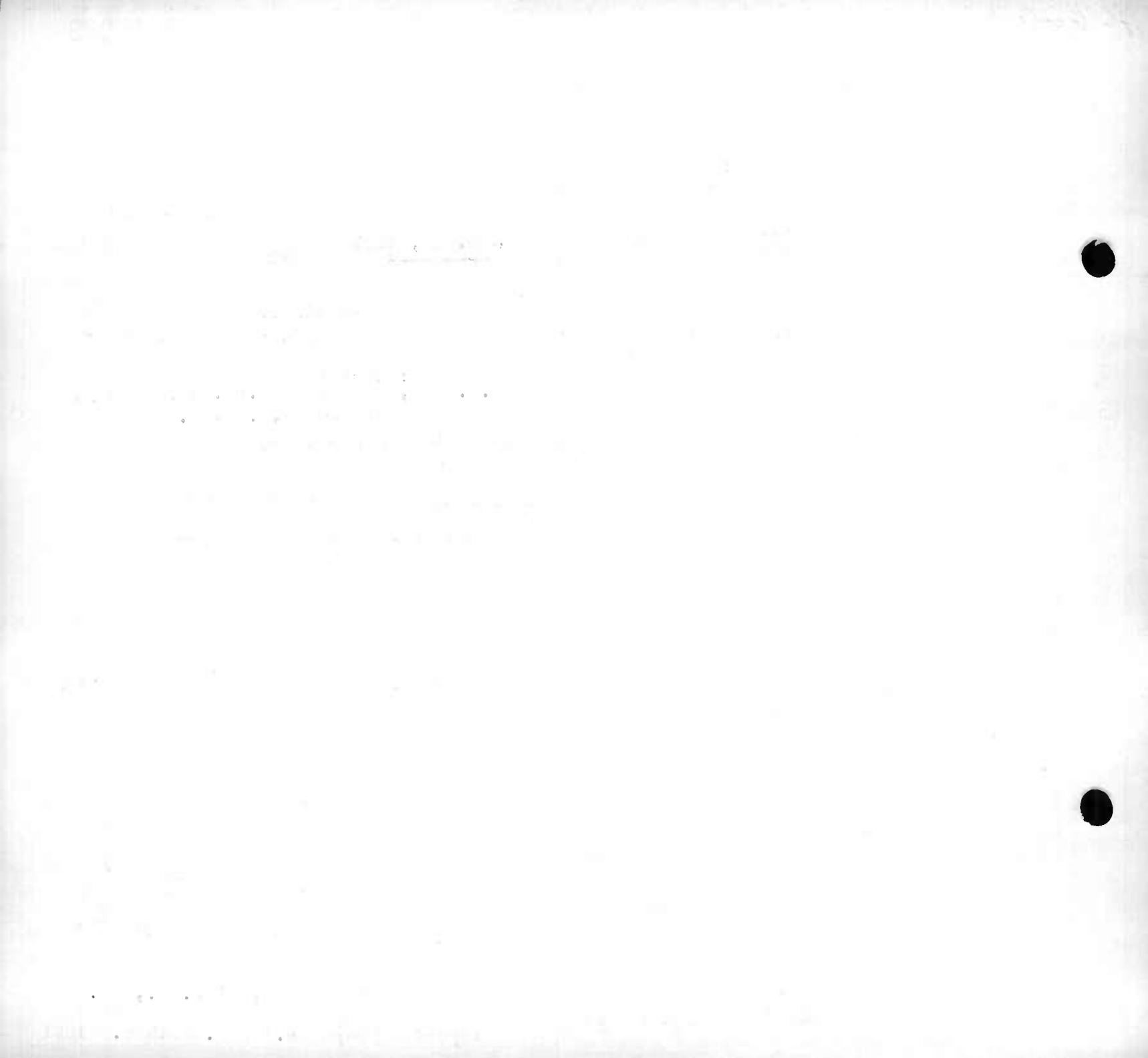
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 10939 CERTIFICATE OF DEATH

REG. NO. 69 10939

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| BIRTH NO.  |  | 1. NAME OF DECEASED<br>(Type or Print) <b>MRS. ALICE MARKELL PARK</b>   |  | 2. DATE AND HOUR OF DEATH<br><b>11-3-69 10 A.M.</b>   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>ANNE ARUNDEL 5200</b>             |  | 5. SEX <b>FEMALE</b>  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>MARYLAND GENERAL HOSPITAL</b>   |  | C. CITY OR TOWN<br><b>PASADENA</b>  |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 6. RACE <b>White CAUC</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>Jan. 29, 1921</b><br><b>04-21-21</b>                                      |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>BOOK-KEEPER</b>  |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>GIBSON ISLE CORP.</b>   |  | 9. AGE (In years last birthday) <b>48</b>   |  |
| 13. FATHER'S NAME<br><b>Charles Markell Falconer CHAS. M. FALCONER</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Ida Elsie Schumacher FDA SCHUMACHER</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>MD. Baltimore</b>                             |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>  |  | 16. SOCIAL SECURITY NO.<br><b>2 16-12-2745</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>   |  |
| 17. INFORMANT: <b>Husband</b><br><b>L.E. Park, 1519 Long Pt. Rd. Sillery Bay, Pasadena, A.A. Co. Md.</b>   |  | ADDRESS<br><b>1519 LONG PT. RD</b>  |  | 17. INFORMANT: <b>Patient</b>   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>HEPATIC CARCINOMATOSIS</b>   |  | CAUSE OF DEATH<br><b>HEPATIC CARCINOMATOSIS</b>   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>UNKNOWN</b>                                |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |  | (A) IMMEDIATE CAUSE<br><b>PROB. TERMINAL</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>METASTATIC CARCINOMA (PROVEN)</b>                                     |  |   |  |
|  |  | (B) <b>CARCINOMA OF LIVER</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>LUNG</b>   |  |   |  |
|  |  | (C) _____   |  |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>LUMBAR DISC DISEASE</b>   |  |   |  |   |  |
| 19A. DATE OF OPERATION<br><b>3-10-69</b>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>HERNIAE N.P. 14-L5</b>   |  | 20A. AUTOPSY? (Yes or No) <b>YES</b>  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                   |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>9-29 19 69</b> to <b>11-3 19 69</b> that (I) (we) last saw the deceased alive on <b>11-3 19 69</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |   |  |   |  |
| 23A. SIGNATURE<br><b>M. J. Whitworth M.D.</b>  |  |   |  | 23B. DATE SIGNED<br><b>11-3-69</b>  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>MICHAEL F. WHITWORTH M.D.</b>   |  |   |  | 23D. ADDRESS<br><b>MD. GENERAL HOSP.</b>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>11/6/69</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge</b>                                      |  |
| 24D. LOCATION<br><b>Pikesville, Balto. Co., Md.</b>  |  | 24E. NAME OF REGISTERAR<br><b>Robert E. Fisher, N.D.</b>  |  | 24F. FUNERAL DIRECTOR<br><b>Stewart &amp; Mowen Co.</b>                                       |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 6 1969</b>   |  | 25B. NAME OF REGISTERAR<br><b>Robert E. Fisher, N.D.</b>  |  | 25C. FUNERAL DIRECTOR<br><b>Stewart &amp; Mowen Co.</b>                                       |  |





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                         |   |  | REG. NO. <span style="font-size: 1.2em;">69 10940</span>           |   |
|---|-------------------------|---|--|--|---|
| 69 10940  |                         |   |  |  |   |
| BIRTH NO.   |                         |   |  |  |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>SISTER MULHOLLAND, ANNA MARIE</b>   |                         |   | 2. DATE AND HOUR OF DEATH<br><b>NOVEMBER 3, 1969   7:05 A. M.</b>  |  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><b>ST AGNES HOSPITAL</b><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>WILKENS &amp; CATON AVENUES</b><br><b>BALTIMORE MARYLAND 21229</b>  |                         |   | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>2831</b> |  |   |
|   |                         |   | C. CITY OR TOWN<br><b>BALTIMORE</b>  |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|   |                         |   | E. STREET AND NUMBER<br><b>6400 WABASH AVENUE</b>  |  |   |
| 5. SEX<br><b>FEMALE</b>   | 6. RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Aug. 08 27 98</b>   | 9. AGE (In years last birthday)<br><b>71</b>                       | If Under 1 Yr. Months Days<br>If Under 24 Hrs. Hours Min.                                     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RELIGIOUS</b>   |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>RELIGIOUS</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>PENNSYLVANIA</b>   |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                         |   |  |  |   |
| 13. FATHER'S NAME<br><b>FRANCIS MULHOLLAND</b>  |                         |   | 14. MOTHER'S MAIDEN NAME<br><b>(DURNEY) MARGARET</b>   |  |   |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |                         |   | 16. SOCIAL SECURITY NO.<br><b>219 54 0071</b>  |  |   |
| 17. INFORMANT<br><b>RECORD'S BALTIMORE MD 21229</b>   |                         |   | 18. ADDRESS<br><b>ST AGNES HOSPITAL WILKENS &amp; CATON AVE</b>  |  |   |
| 18. CAUSE OF DEATH<br><b>157.0 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Carcinoma of head of</b><br>(A) IMMEDIATE CAUSE<br><b>DUE TO, OR AS A CONSEQUENCE OF:</b><br><b>primary metastasis</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                         |   |  |  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                         |   |  |  |   |
| 19A. DATE OF OPERATION<br><b>2</b>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>                             |   |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                         |   |  |  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)   |  |  |   |
| 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |                         |   |  |  |   |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)  |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (X) (this hospital) attended the deceased from <b>OCTOBER 8, 19 69</b> to <b>NOVEMBER 3, 19 69</b> that (X) (we) last saw the deceased alive on <b>NOVEMBER 3, 19 69</b> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.   |                         |   |  |  |   |
| 23A. SIGNATURE<br><b>C. J. Lancelotta M.D.</b>  |                         |   | 23B. DATE SIGNED<br><b>11/3/69</b>   |  |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>C LANCELOTTA, M.D.</b>   |                         |   | 23D. ADDRESS<br><b>BALTIMORE MD 21229</b><br><b>ST AGNES HOSPITAL WILKENS &amp; CATON AVE</b>  |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 24B. DATE<br><b>11/5/69</b>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>St. Joseph's Cemetery</b> |   |
| 24D. LOCATION<br>(City, town, or county) (State)<br><b>Emmitsburg, Maryland</b>   |                         |   |  |  |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 6 1969</b>  |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher, M.D.</b>   |  | 25C. FUNERAL DIRECTOR<br><b>Stewart &amp; Mullen Co.</b>           |   |
| 25D. ADDRESS<br><b>108 W. North Av. 21201</b>   |                         |   |  |  |   |

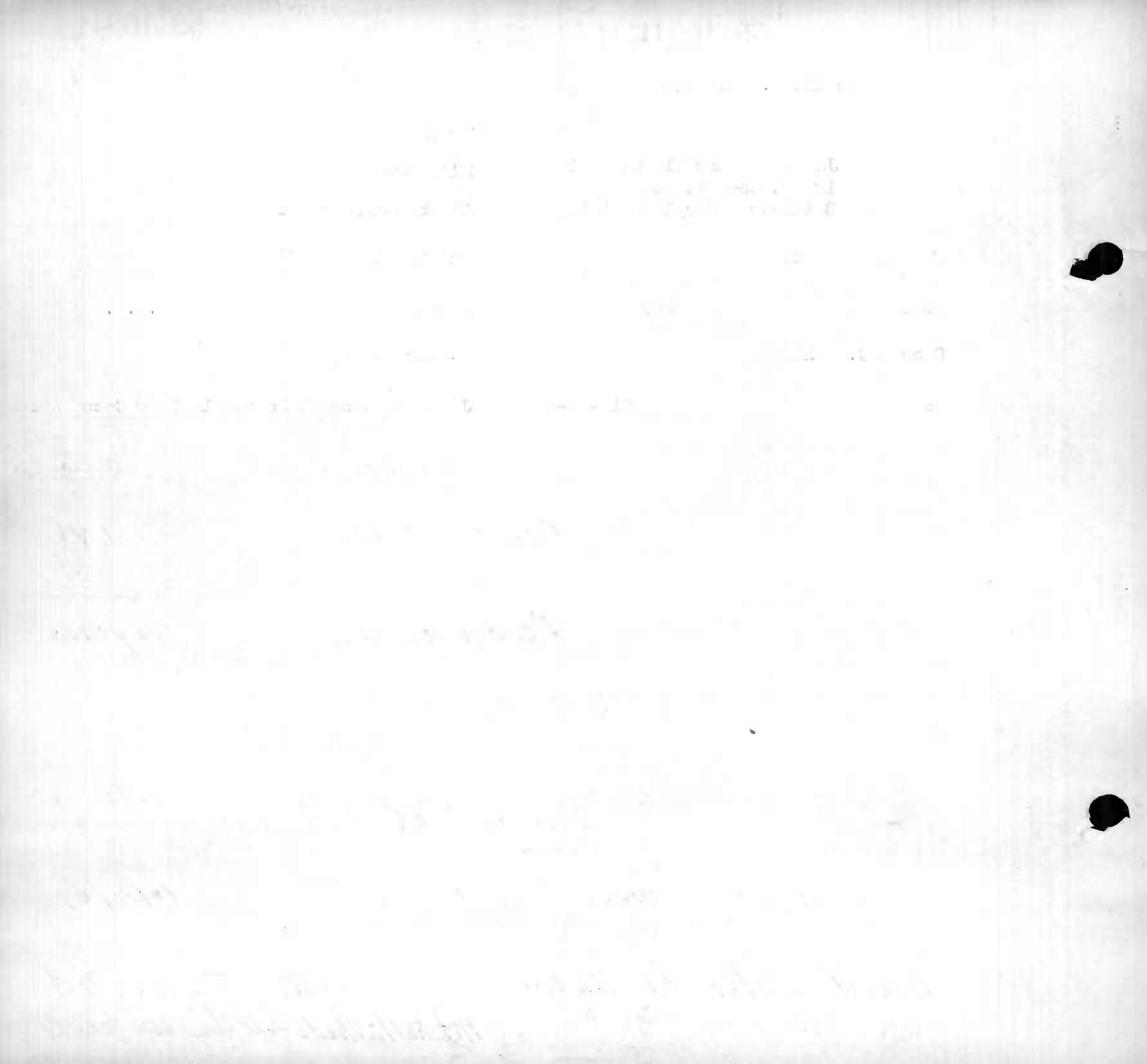
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1. *Journal of Management Studies*, 1990, 27, 1.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |  |  |  | REG. NO. <b>69 10941</b>   |
|--|--|--|--|--|
| BIRTH NO. <b>69 10941</b>  |  | <b>CERTIFICATE OF DEATH</b>  |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Lucille M. Mulligan</b>  |  | 2. DATE AND HOUR OF DEATH<br><b>10/30/69 10:37AM.</b> M.   |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Jenkins Memorial Hospital</b><br>ADDRESS OR LOCATION<br><b>1000 Caton Avenue<br/>Baltimore, Maryland 21229</b>  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>2712</b>   |  |  |
| 5. SEX <b>Female</b>   |  | 6. RACE <b>White</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH <b>March 25, 1898</b>   |  | 9. AGE (In years last birthday) <b>71</b>  |  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>  |  | 10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>  |  | 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 13. FATHER'S NAME <b>George C. Mulligan</b>  |  |  |
| 14. MOTHER'S MAIDEN NAME <b>Katherine Boyd</b>   |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>   |  |  |
| 16. SOCIAL SECURITY NO. <b>213-54-0300</b>   |  | 17. INFORMANT <b>Jenkins Memorial Hospital</b> ADDRESS <b>1000 Caton Avenue</b>  |  |  |
| 18. <b>153.8 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Cachexia</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Cancer colon</b><br><b>1</b> |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>Cachexia</b><br>(B) <b>Cancer colon</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>1</b><br>(C) <b>1</b> |  |  |
| 19. DATE OF OPERATION <b>10/30/69</b>  |  | 20. AUTOPSY? (Yes or No) <b>No</b>   |  | 21. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>10 years</b>  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Dec 6 1958</b> to <b>10/30 1969</b> , that (I) (we) lost saw the deceased alive on <b>10/30 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.   |  |  |  |  |
| 23A. SIGNATURE <b>J. Raymond Gladu</b>   |  | 23B. DATE SIGNED <b>10/30/69</b>   |  | 23C. PHYSICIAN'S NAME (Type) <b>Robert E. Gable, M.D.</b>  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 24B. DATE <b>11/3/69</b>   |  | 24C. NAME OF CEMETERY or CREMATORY <b>Mt. Maria</b>  |
| 24D. LOCATION (City, town, or county) (State) <b>York Rd Towson, Md</b>  |  | 25A. DATE REC'D BY HEALTH DEPT. <b>NOV 6 1969</b>  |  |  |
| 25B. NAME OF REGISTRAR <b>Robert E. Gable, M.D.</b>  |  | 25C. FUNERAL DIRECTOR <b>Robert E. Gable, M.D.</b> ADDRESS <b>6500 York Rd BALTO., MD. 21212</b>   |  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

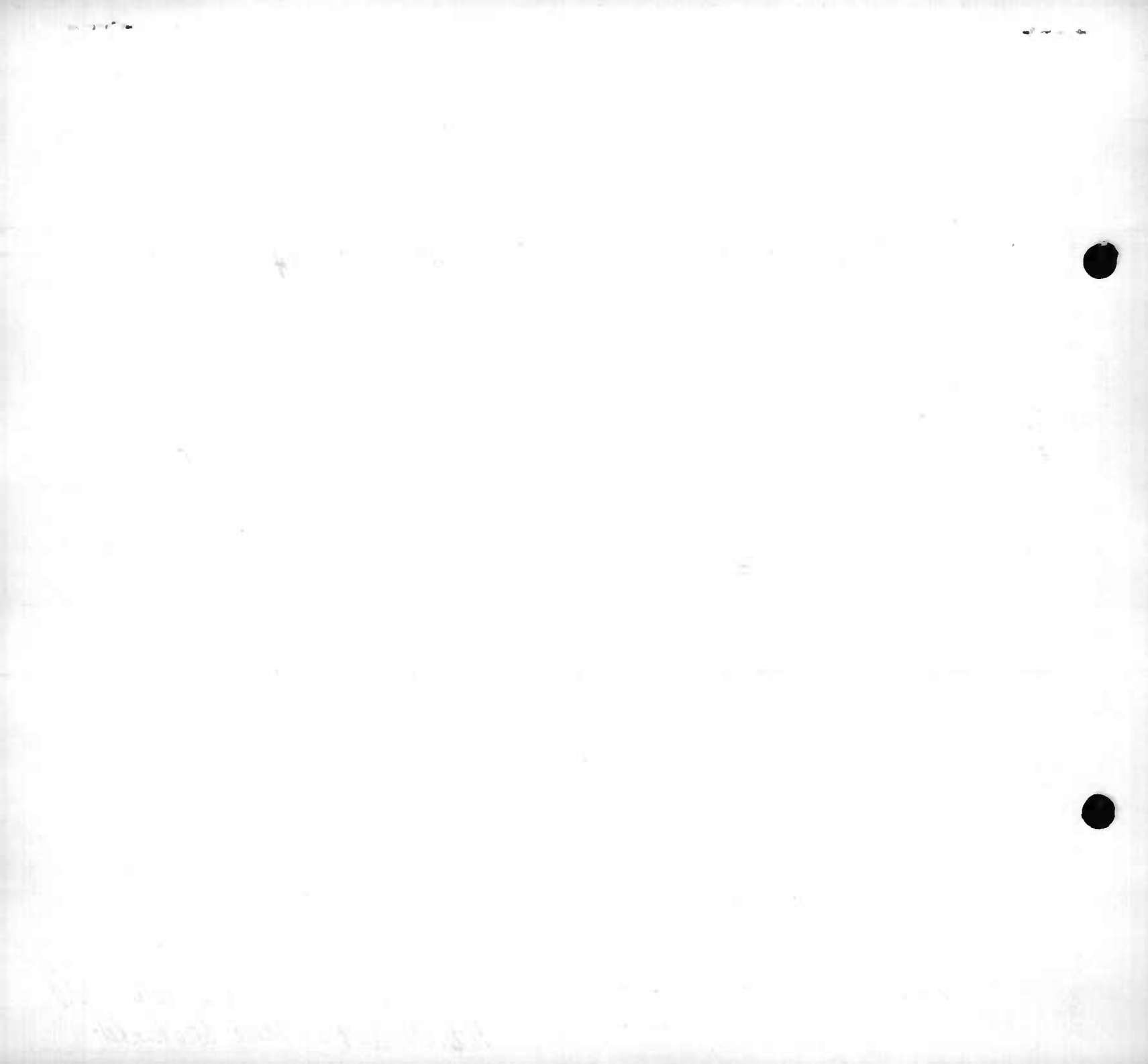
69 10942

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

69 10942

|   |                     |   |  |   |                                     |
|---|---------------------|---|--|---|-------------------------------------|
| BIRTH NO.   |                     | 1. NAME OF DECEASED<br>(Type or Print) <b>KATHRYN L. BEHRENS</b>  |  | 2. DATE AND HOUR OF DEATH<br><b>11/3/69</b> <b>5:20 P.M.</b>  |                                     |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                     |   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                                       |                                     |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>UNION MEMORIAL HOSPITAL</b><br><b>44</b>   |                     | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |  | A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> <b>1307</b>   |                                     |
|   |                     |   |  | C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                     |
|   |                     |   |  | E. STREET AND NUMBER<br><b>609 W. 40th Street</b>   |                                     |
| 5. SEX<br><b>F</b>  | 6. RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>11/26/94</b>   | 9. AGE (In last birthday) <b>74</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>TUTOR</b>   |                     | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>ILLINOIS</b>  |                                     |
| 13. FATHER'S NAME<br><b>MR CHARLES F. BEHRENS</b>   |                     |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                     |
| 14. MOTHER'S MAIDEN NAME<br><b>MRS LAURA BEHRENS</b>  |                     |   |  |   |                                     |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |                     | 16. SOCIAL SECURITY NO.<br><b>216-07-3633</b>   |  | 17. INFORMANT<br><b>MRS E. KING SCHULTZ</b>   |                                     |
|   |                     |   |  | ADDRESS<br><b>609 W 40th St. Balt. Md.</b>  |                                     |
| 18. CAUSE OF DEATH  |                     |   |  |   |                                     |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  |                     |   |  |   |                                     |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                     |   |  |   |                                     |
| (A) IMMEDIATE CAUSE <b>myocardial failure</b><br>DUE TO, OR AS A CONSEQUENCE OF:  |                     |   |  |   |                                     |
| (B) <b>ASCVD and Mitral insufficiency 3 years</b><br>DUE TO, OR AS A CONSEQUENCE OF:  |                     |   |  |   |                                     |
| (C) <b>2° to Subacute Bacterial Endocarditis</b>  |                     |   |  |   |                                     |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                     |   |  |   |                                     |
| 19A. DATE OF OPERATION<br><b>0</b>  |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>  |                                     |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examined) <input type="checkbox"/>  |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                                     |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                     | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?  |                                     |
| 22. I certify that (1) (this hospital) attended the deceased from <b>11/2</b> 19 <b>69</b> to <b>11/3</b> 19 <b>69</b> that (1) (we) last saw the deceased alive on <b>11/3</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. |                     |   |  |   |                                     |
| 23A. SIGNATURE<br><b>Anne L. Ledy M.D.</b>  |                     |   |  | 23B. DATE SIGNED<br><b>11/3/69</b>  |                                     |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Anne L. Ledy</b>   |                     |   |  | 23D. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>  |                                     |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                     | 24B. DATE<br><b>11/5/69</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Cemetery</b>  |                                     |
| 24D. LOCATION (City, town, or county) (State)<br><b>Jesswood Rd Woodlawn Balt. Md</b>   |                     | 24E. DATE REC'D BY HEALTH DEPT.<br><b>NOV 6 1969</b>  |  | 24F. NAME OF REGISTRAR<br><b>Robert E. Garber, M.D.</b>   |                                     |
| 24G. FUNERAL DIRECTOR<br><b>Michael J. Garber</b>   |                     | 24H. ADDRESS<br><b>Home - 6500 York Rd.</b>   |  |   |                                     |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |  |                               |   | REG. NO. <b>69 10943</b> |  |
|--|--|-------------------------------|---|--------------------------|--|
| BIRTH NO. <b>69 10943</b>  |  | 69 10943 CERTIFICATE OF DEATH |   |                          |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>JOSEPH CHAMBERS</b>  |  |                               | 2. DATE AND HOUR OF DEATH<br><b>11-3-1969 7: A. M.</b>  |                          |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>3621 Kenyon Avenue</b>   |  |                               | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>26 43</b> |                          |  |
| 5. SEX <b>MALE</b>   |  |                               | 6. RACE <b>WHITE</b>  |                          | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> <b>separated</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Radio &amp; Television Shop, Own Business</b>  |  |                               | 10B. KIND OF BUSINESS OR INDUSTRY   |                          | 8. DATE OF BIRTH <b>March 10-1925</b>  |
| 13. FATHER'S NAME<br><b>Albert J. Chambers Sr.</b>   |  |                               | 14. MOTHER'S MAIDEN NAME<br><b>Marie Baumgartner</b>  |                          | 9. AGE (In years last birthday) <b>44</b><br>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |  |                               | 16. SOCIAL SECURITY NO.<br><b>214-24-5394</b>   |                          | 17. INFORMANT<br><b>Mr. Joseph M. Frank</b>  |
| 18. <b>162.1 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)<br><b>Chronic Bronchial Cancer</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br>19A. DATE OF OPERATION <b>August 1968</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Bronchopneumonia</b> |  |                               | 20A. AUTOPSY? (Yes or No) <b>no</b>   |                          | 12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |  |                               | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                          | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  |  |                               | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                   |                          | 21F. HOW DID INJURY OCCUR?   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>August 1968</b> to <b>January 3 1969</b> , that (I) (we) last saw the deceased alive on <b>November 2 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |                               |   |                          |  |
| 23A. SIGNATURE<br><b>Melvin F. Polek, M.D.</b>   |  |                               | 23B. DATE SIGNED<br><b>11/4/69</b>  |                          | 23C. PHYSICIAN'S NAME (Type)<br><b>Dr. Melvin F. Polek</b>   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |                               | 24B. DATE<br><b>Nov. 6, 1969</b>  |                          | 24C. NAME of CEMETERY or CREMATORY<br><b>Moreland Memorial Cemetery</b>  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 6 1969</b>   |  |                               | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher, M.D.</b>   |                          | 25C. FUNERAL DIRECTOR<br><b>Schimunek Funeral Home, 3331 Brehms Lane</b>   |
| 24D. LOCATION (City, town, or county)<br><b>Baltimore, Md.</b>   |  |                               | 24E. ADDRESS  |                          |  |

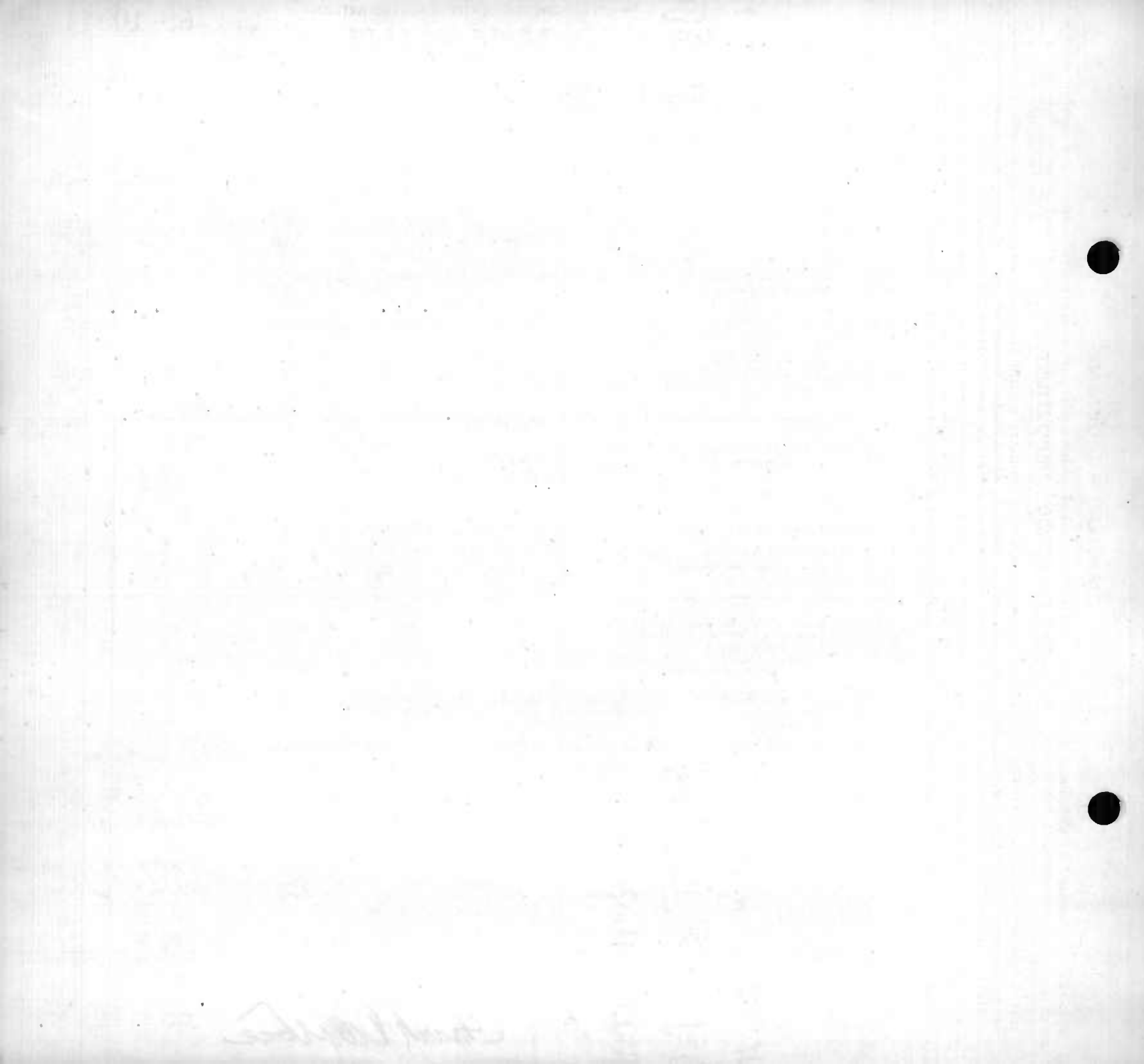




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |   |   |  | REG. NO. <span style="font-size: 1.2em;">69 10944</span>  |   |
|---|---|---|--|---|---|
| <div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. <span style="font-size: 1.2em;">62-34512 69 10944</span></span> <span style="font-size: 1.5em;">CERTIFICATE OF DEATH</span> </div>   |   |   |  |   |   |
| 1. NAME OF DECEASED<br>(Type or Print) <span style="font-size: 1.1em;">MARY BLOUNT OR MARY DIANE BLOUNT</span>  |   |   | 2. DATE AND HOUR OF DEATH<br><span style="font-size: 1.1em;">NOV. 3, 1969 11:10 P M.</span>  |   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><br><span style="font-size: 1.1em;">33 THE JOHNS HOPKINS HOSPITAL</span>   |   |   | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence, before admission)<br>A. STATE <span style="font-size: 1.1em;">MD.</span><br>B. COUNTY <span style="font-size: 1.1em;">BALTIMORE</span><br>C. CITY OR TOWN <span style="font-size: 1.1em;">BALTIMORE</span><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <span style="font-size: 1.1em;">211 S. SPRING COURT</span> |   |   |
| 5. SEX<br><span style="font-size: 1.1em;">FEMALE</span>   | 6. RACE<br><span style="font-size: 1.1em;">WHITE</span>     | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><span style="font-size: 1.1em;">12-07-62</span>  | 9. AGE (In years last birthday)<br><span style="font-size: 1.1em;">6</span>                             | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |   |   | 11. BIRTHPLACE (State or foreign country)<br><span style="font-size: 1.1em;">BALTO. Md.</span>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><span style="font-size: 1.1em;">U.S.A.</span>   |
| 13. FATHER'S NAME<br><span style="font-size: 1.1em;">WILLIAM F. BLOUNT</span>   |   |   | 14. MOTHER'S MAIDEN NAME<br><span style="font-size: 1.1em;">SALLY PENDER</span>  |   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |   | 16. SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS<br><span style="font-size: 1.1em;">MR. WILLIAM BLOUNT 211 SPRING CT.</span>  |   |   |
| 18. <span style="font-size: 1.2em;">204.0 I</span><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                  |   |   | CAUSE OF DEATH<br><span style="font-size: 1.2em;">Sepsis (Pseudomonas)</span><br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><span style="font-size: 1.2em;">GRANULOCYTOPENIA</span><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><span style="font-size: 1.2em;">ACUTE Lymphocytic Leukemia</span><br>(C) <span style="font-size: 1.2em;">ACUTE Lymphocytic Leukemia</span>   |   |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |   |   |  |   |   |
| 19A. DATE OF OPERATION<br><span style="font-size: 1.2em;">2</span>  |   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><span style="font-size: 1.1em;">YES</span>                                 |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)   |   | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.1em;">10/13/69</span> 19 to <span style="font-size: 1.1em;">11/4</span> 1969, that (I) (we) last saw the deceased alive on <span style="font-size: 1.1em;">11/4</span> 1969 and that (my) (our) apian death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |   |   |  |   |   |
| 23A. SIGNATURE<br><span style="font-size: 1.2em;">Carmela Tardo, MD</span>  |   |   | 23B. DATE SIGNED<br><span style="font-size: 1.2em;">11/4/69</span>   |   | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |
| 23C. PHYSICIAN'S NAME (Type)<br><span style="font-size: 1.1em;">CARMELA L. TARDO, M.D.</span>   |   |   | 23D. ADDRESS<br><span style="font-size: 1.1em;">THE JOHNS HOPKINS HOSPITAL</span>  |   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><span style="font-size: 1.1em;">BURIAL</span>   | 24B. DATE<br><span style="font-size: 1.1em;">11/7/69</span> | 24C. NAME OF CEMETERY or CREMATORY<br><span style="font-size: 1.1em;">GLEN HAVEN</span>   |  | 24D. LOCATION (City, town, or county) (State)<br><span style="font-size: 1.1em;">GLEN BURNIE Md.</span> |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><span style="font-size: 1.2em;">NOV 6 1969</span>  |   | 25B. NAME OF REGISTRAR<br><span style="font-size: 1.2em;">Robert E. Taylor</span>   |  | 25C. FUNERAL DIRECTOR ADDRESS<br><span style="font-size: 1.2em;">Frank L. Taylor 322 S. HIGH ST.</span> |   |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 10945

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

69 10945

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

SMITH, ALBERT

2. DATE AND HOUR OF DEATH

11/4/69

2<sup>00</sup>

P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)UNIVERSITY OF MARYLAND  
HOSPITAL  
38

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

11<sup>th</sup> CO.

C. CITY OR TOWN

Hagerwood, MD

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

5200

5. SEX

M

6. RACE

N

7. MARRIED ☐NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

5-2-27

9. AGE (in years  
last birthday)

42

If Under 1 Yr.

Months

Days

If Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Daniel Smith

14. MOTHER'S MAIDEN NAME

Emma Sellman

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. 560.9 I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Malabsorption secondary to  
resection of small bowel

(B) Gangrenous small bowel

DUE TO, OR AS A CONSEQUENCE OF:

obstruction

(C) \_\_\_\_\_

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

8/21/69

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

Gangrenous small bowel ob.

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (Notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Nov. 1/69 to Nov. 4 1969  
that (I) (we) last saw the deceased alive on Nov. 4 1969 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

[Signature]

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

11/4/69

23C. PHYSICIAN'S  
NAME (Type)

23D. ADDRESS

DEGREE

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

11-8-69

24C. NAME of CEMETERY or CREMATORY

St. Marks Cemetery

24D. LOCATION

City, town, or county

(State)

Mayo, Md.

25A. DATE REC'D BY HEALTH DEPT.

NOV 6 1969

25B. NAME OF REGISTRAR

Philip E. Taber, M.D.

25C. FUNERAL DIRECTOR

Bease Fur Home

ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 10946

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

69 10946

REG. NO.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

ARTHUR ALLEN REISINGER

2. DATE AND HOUR OF DEATH

11-4-1969

11:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

MONTEBELLO STATE Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

A. STATE

B. COUNTY

MD

BALTIMORE

2531

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

4919 FREDERICK AVE

5. SEX

M

6. RACE

W

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

9/5/1888

9. AGE (in years last birthday)

81

If Under 1 Yr. Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

GEORGE REISINGER

14. MOTHER'S MAIDEN NAME

Mary

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

217-05-2097A

17. INFORMANT

ADDRESS

MONTEBELLO STATE Hosp. Records

18.

237.6 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

BLADDER TUMOR

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

8 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐

OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3-26 1968 to 11-4 1969

that (I) (we) last saw the deceased alive on 11-4 1969 and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

J. Fuxa

MD

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type)

JORGE G. FUXA

MD

23D. ADDRESS

2201 ARGONNE DR. BALTIMORE.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/8/69

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 6 1969

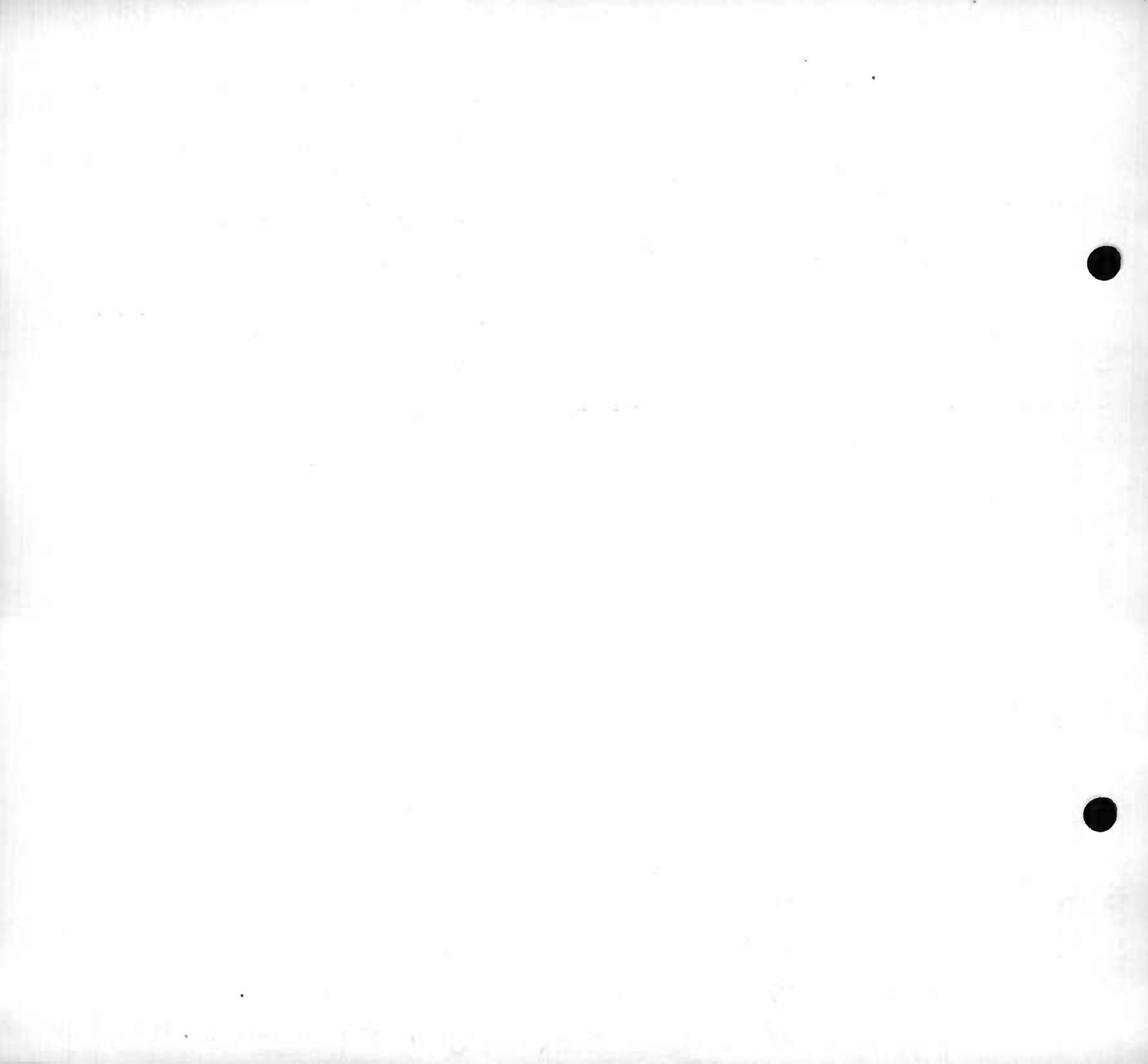
25B. NAME OF REGISTRAR

Robert E. Tabor, M.D.

25C. FUNERAL DIRECTOR

Witzke, 1630 Edmondson Ave. Catonsville

ADDRESS



69 10947 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 10947

BIRTH NO.

## 1. NAME OF DECEASED

(Type or Print)

Mabel Shirey

## 2. DATE OF DEATH

Known ☒ Estimated ☐

Month

Day

Year

Hour

11

4

69

10:00 a.m.

## 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

46 Lutheran Hospital

## 3. DATE PRONOUNCED DEAD

Month

Day

Year

Hour

11

4

69

10:00 a.m.

## 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

2864

## 6. SEX

female

## 7. RACE

white

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

## C. CITY OR TOWN

Baltimore

## D. INSIDE CITY LIMITS?

YES ☒NO ☐

## 9. DATE OF BIRTH

5/26/02

## 10. AGE (In years lost birthday)

67

## If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

## E. STREET AND NUMBER

4516 Old Frederick Rd.

## 11. BIRTHPLACE (State or foreign country)

Penna

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

Robert McKinney

## 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

## 14B. KIND OF BUSINESS OR INDUSTRY

## 15. MOTHER'S MAIDEN NAME

Sadie

## 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

## 17. SOCIAL SECURITY NO.

214-01-2248

## 18. INFORMANT

## ADDRESS

Mr. Percy I. Shirey, 4516 Old Frederick Rd.

412.21

## CAUSE OF DEATH

## APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

## DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Hypertensive cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

## 20A. DATE OF OPERATION

## 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

## 21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

## 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

## 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

## 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

## 22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

## 22F. HOW DID INJURY OCCUR?

## 23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

Deputy Chief Medical Examiner

DATE SIGNED

11/4/69

## 24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

## 24B. DATE

11/7/69

## 24C. NAME OF CEMETERY or CREMATORY

Baltimore National Cem.

## 24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

## 25A. DATE REC'D BY HEALTH DEPT.

NOV 6 1969

## 25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

## 25C. FUNERAL DIRECTOR

Witzke, 1630 Edmondson Ave., Catonsville

## ADDRESS

21228

1901

1901

WALTER  
1901



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

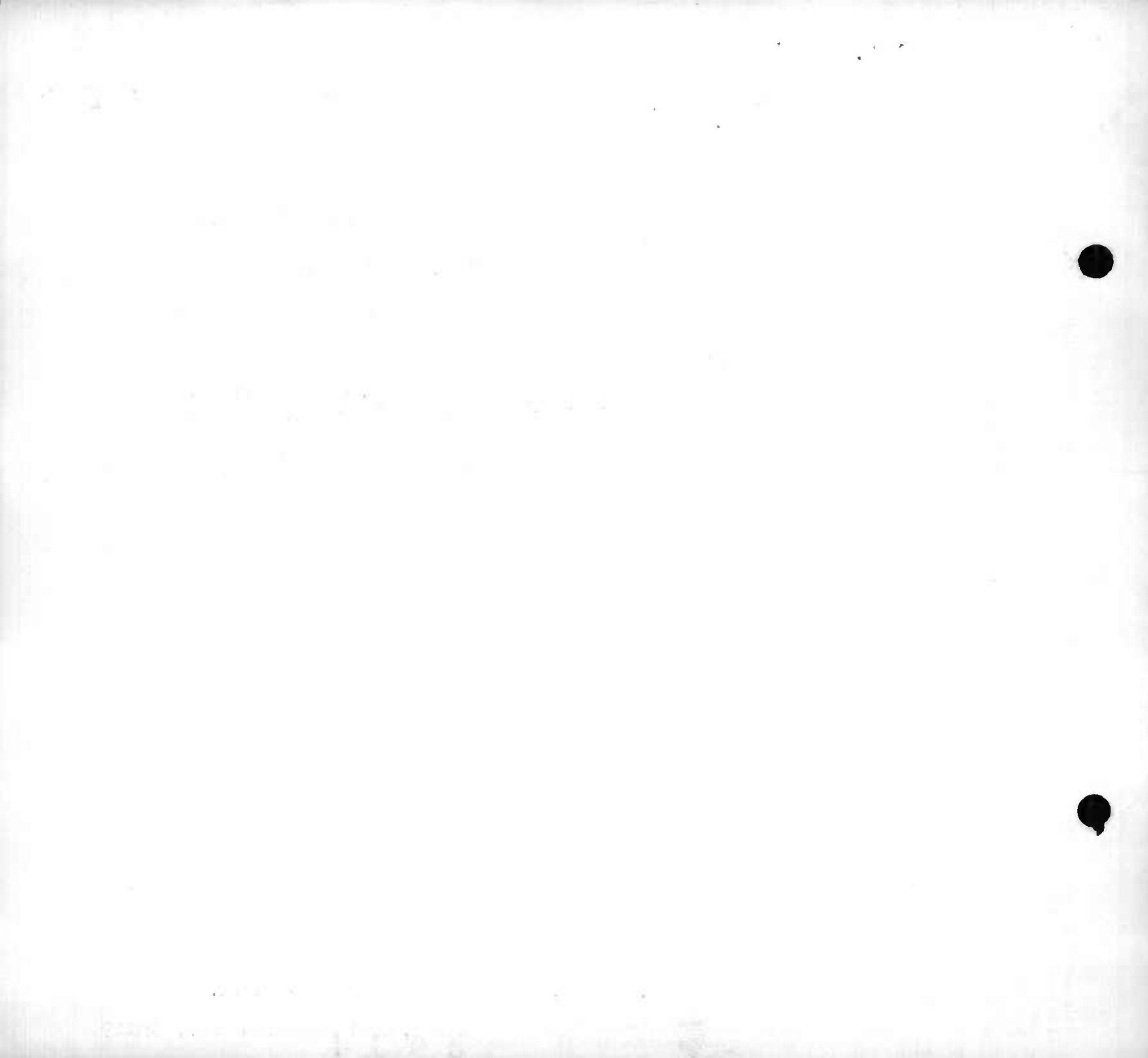
| Baltimore City Health Department  |   |   |  | REG. NO. <span style="font-size: 1.2em;">69 10948</span>  |   |
|---|---|---|--|---|---|
| BIRTH NO. <span style="font-size: 1.2em;">69 10948</span>   |   | CERTIFICATE OF DEATH  |  |   |   |
| 1. NAME OF DECEASED<br>(Type or Print) <span style="font-size: 1.1em;">Hazel Whiteford</span>   |   |   | 2. DATE AND HOUR OF DEATH<br><span style="font-size: 1.1em;">11/4/69</span> <span style="float: right;">11:30a.m.</span>                   |   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |   |   | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)  |   |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><span style="font-size: 1.1em;">House in the Pines -Belvedere</span><br><span style="font-size: 1.1em;">2525 W. Belvedere Avenue</span><br><span style="font-size: 1.1em;">Baltimore, Md.</span>  |   |   | A. STATE <span style="font-size: 1.1em;">Md.</span><br>B. COUNTY <span style="font-size: 1.1em;">2037</span>                               |   |   |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |   |   | C. CITY OR TOWN<br><span style="font-size: 1.1em;">Baltimore</span>  |   | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |
| 90  |   |   | E. STREET AND NUMBER<br><span style="font-size: 1.1em;">239 N. Monastery Avenue</span>   |   |   |
| 5. SEX<br><span style="font-size: 1.1em;">female</span>   | 6. RACE<br><span style="font-size: 1.1em;">white</span> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><span style="font-size: 1.1em;">10/22/1890</span>  | 9. AGE (In years lost birthday)<br><span style="font-size: 1.1em;">79</span>                          | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><span style="font-size: 1.1em;">Housewife</span>   |   |   | 11. BIRTHPLACE (State or foreign country)<br><span style="font-size: 1.1em;">Maryland</span>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><span style="font-size: 1.1em;">U.S.A.</span>                       |
| 13. FATHER'S NAME<br><span style="font-size: 1.1em;">George A. Harkins</span>   |   |   | 14. MOTHER'S MAIDEN NAME<br><span style="font-size: 1.1em;">Sarah L. Quinlan</span>  |   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |   |   | 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br><span style="font-size: 1.1em;">Miss Mary E. Harkins, 239 N. Monastery Ave.</span> |
| 18. <span style="font-size: 1.2em;">410.9 I</span><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><span style="font-size: 1.1em;">Coronary occlusion</span>   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><span style="font-size: 1.1em;">15 minutes</span>  |   |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |   |   | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><span style="font-size: 1.1em;">ASCD = cerebral and coronary insuff. were</span> |   |   |
| (B) DUE TO, OR AS A CONSEQUENCE OF:   |   |   | (C) DUE TO, OR AS A CONSEQUENCE OF:  |   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |   |   |  |   |   |
| 19A. DATE OF OPERATION<br><span style="font-size: 1.1em;">0</span>  |   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                              |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |   | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.1em;">10/13/69</span> 19 to <span style="font-size: 1.1em;">11/4/69</span> 19, that (I) ( <del>we</del> ) lost saw the deceased alive on <span style="font-size: 1.1em;">10/30/69</span> 19 and that fn(my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>not</del> ) view the body after death. |   |   |  |   |   |
| 23A. SIGNATURE<br><span style="font-size: 1.1em;">[Signature]</span>  |   |   |  | 23B. DATE SIGNED<br><span style="font-size: 1.1em;">11/5/69</span>                                    |   |
| 23C. PHYSICIAN'S NAME (Type)<br><span style="font-size: 1.1em;">Dr. I. W. Fromm</span>  |   |   |  | 23D. ADDRESS<br><span style="font-size: 1.1em;">8014 Old Harford Road</span>                          |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |   | 24B. DATE<br><span style="font-size: 1.1em;">11/7/69</span>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><span style="font-size: 1.1em;">Centre M. E. Church Cem.</span> |   |
| 24D. LOCATION (City, town, or county) (State)<br><span style="font-size: 1.1em;">Forest Hills, Md.</span>   |   | 24E. FUNERAL DIRECTOR<br><span style="font-size: 1.1em;">Witzke, 3600 Edmondson Ave. 21229</span>   |  | 24F. ADDRESS<br><span style="font-size: 1.1em;">Catonsville</span>                                    |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><span style="font-size: 1.1em;">NOV 6 1969</span>  |   | 25B. NAME OF REGISTRAR<br><span style="font-size: 1.1em;">Robert E. Jolley, M.D.</span>   |  | 25C. FUNERAL DIRECTOR<br><span style="font-size: 1.1em;">Witzke, 3600 Edmondson Ave. 21229</span>     |   |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 69 10949  |  | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH   |  | REG. NO. 69 10949   |  |
| BIRTH NO.   |  | 1. NAME OF DECEASED<br>(Type or Print) <b>KIDWELL, PANSEY</b>  |  | 2. DATE AND HOUR OF DEATH<br><b>Nov. 3, 1969 3:45 P.M.</b>                                    |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>-</b>  |  | 5. CITY OR TOWN <b>Baltimore</b>  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Bon Secours Hospital</b>   |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 6. SEX <b>Female</b>  |  | 7. RACE <b>White</b>   |  | 8. DATE OF BIRTH <b>JUNE 7, 1913</b>  |  |
| 9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   |  | 10. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. AGE (in years last birthday) <b>56</b>   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country) <b>Virginia</b>                                     |  |
| 13. FATHER'S NAME <b>William Showalter</b>  |  | 14. MOTHER'S MAIDEN NAME <b>UNKNOWN Ann</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                    |  | 16. SOCIAL SECURITY NO. <b>578-24-5920</b>   |  | 17. INFORMANT <b>Mrs. Rosetta Hinkle, Chart 2651 Lehman Court</b>                             |  |
| 18. <b>428X1</b>  |  | CAUSE OF DEATH   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |  | (A) IMMEDIATE CAUSE <b>Myocardial disease</b>  |  | <b>one week</b>   |  |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) |  | DUE TO, OR AS A CONSEQUENCE OF:  |  |   |  |
| ANTECEDENT CAUSES   |  | (B) _____  |  |   |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                   |  | DUE TO, OR AS A CONSEQUENCE OF:  |  |   |  |
| (C) _____   |  |  |  |   |  |
| II  |  |  |  |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).            |  |  |  |   |  |
| 19A. DATE OF OPERATION <b>0</b>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No) <b>NO</b>   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10/30</b> 19 <b>69</b> to <b>11/3</b> 19 <b>69</b>                     |  | that (I) (we) last saw the deceased alive on <b>11/3</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |   |  |
| 23A. SIGNATURE <b>M. Abbas M.D.</b>   |  | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>  |  | 23B. DATE SIGNED <b>11/3/69</b>   |  |
| 23C. PHYSICIAN'S NAME (Type) <b>Mahmoud Abbas M.D.</b>  |  | 23D. ADDRESS <b>Bon Secours Hospital</b>   |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 24B. DATE <b>11/6/69</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Hebron,</b>   |  |
| 24D. LOCATION (City, town, or county) (State) <b>Winchester, Va.</b>  |  | 25A. DATE REC'D BY HEALTH DEPT. <b>NOV 6 1969</b>  |  | 25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>  |  |
| 25C. FUNERAL DIRECTOR <b>Witzke, 4101 Edmondson Ave., 21229</b>   |  | ADDRESS  |  |   |  |



E-1201

69 10950

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

69 10950

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

HENRY Lee Epps

2. DATE AND HOUR OF DEATH

11-3-69 205

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)JOHNS HOPKINS HOSPITAL  
601 N. BROADWAY  
BALTIMORE, MARYLAND

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

2741 TIVOLY AVENUE

5. SEX

MALE

6. RACE

NEGRO

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

7/31/30

9. AGE (in years  
last birthday)

39

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Truck Driver

10B. KIND OF BUSINESS OR INDUSTRY

Suburban Club  
Bottling Co.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

THADEUS EPPS

14. MOTHER'S MAIDEN NAME

ROSA B. EPPS

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMANT

1925 W. Saratoga St.

ADDRESS

Austratia Epps

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

Possible GI bleed

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

15 min

(B) DUE TO, OR AS A CONSEQUENCE OF:

Delirium tremens, EtOHism

72 hrs

hepatitis, hypotension, sepsis, pneumonia  
pneumococcal pneumonia

72 hrs

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (the hospital) attended the deceased from 10/31/69 1969 to 11-3-69 1969  
that (1) (we) last saw the deceased alive on 11-3-69 1969 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Hayden G. Braine

DEGREE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

11-3-69

23C. PHYSICIAN'S  
NAME (Type)

HAYDEN G. BRAINE

M.D.

THE JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

11-7-69

24C. NAME OF CEMETERY OR CREMATORY

Arbutus Memorial Pk.

24D. LOCATION

(City, town, or county)

(State)

BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

NOV 6

1969

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

1735 Harford Ave. ADDRESS  
Marshall W. Jones, Jr.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

OSL 2

11 03 69

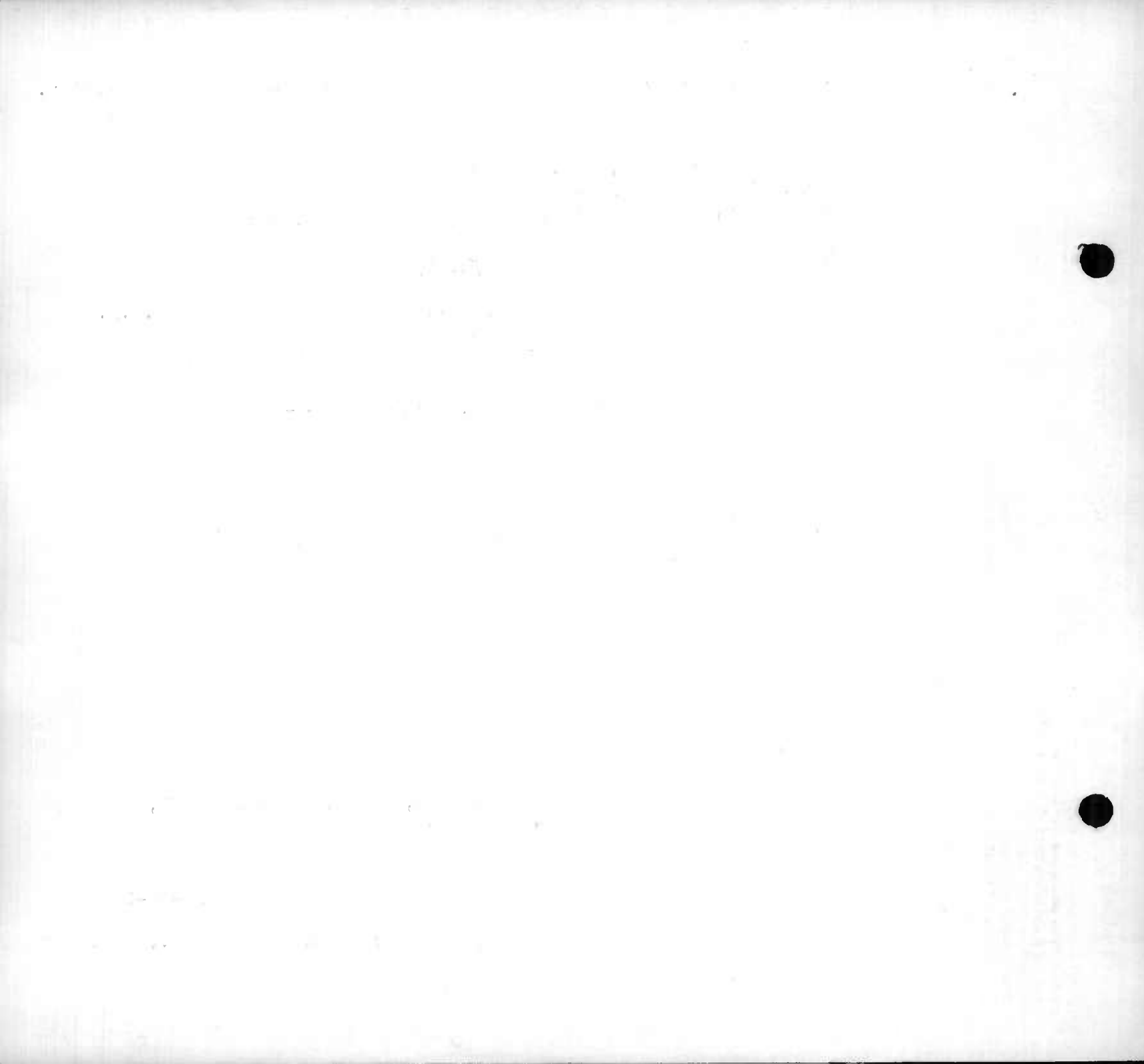


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-626 1

| BALTIMORE CITY HEALTH DEPARTMENT   |  |   |  | REG. NO. <span style="font-size: 1.2em;">69 10951</span>  |  |
|--|--|---|--|---|--|
| 69 10951   |  |   |  | CERTIFICATE OF DEATH  |  |
| BIRTH NO.  |  | 1. NAME OF DECEASED<br>(Type or Print)  |  | 2. DATE AND HOUR OF DEATH   |  |
|  |  | Odell Parker  |  | 10-31-69 2:45 a.m.  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>Provident Hospital, Inc.<br>1514 Division Street<br>Baltimore, Maryland 21217   |  |   |  | A. STATE<br>Maryland  |  |
|  |  |   |  | B. COUNTY<br>1403   |  |
| 5. SEX<br>Male   |  |   |  | 6. RACE<br>Negro  |  |
|  |  |   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH<br>3/10/13  |  |   |  | 9. AGE (in years last birthday)<br>55   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Unemployed  |  |   |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (State or foreign country)<br>Virginia  |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |
| 13. FATHER'S NAME<br>????  |  |   |  | 14. MOTHER'S MAIDEN NAME<br>????  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |  |   |  | 16. SOCIAL SECURITY NO.<br>230-42-5673  |  |
| 17. INFORMANT<br>Mrs. Madlee Parker- Wife  |  |   |  | ADDRESS<br>SAME   |  |
| 18. CAUSE OF DEATH   |  |   |  |   |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><i>2 Hemia</i><br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><i>Cerebrovascular Accident</i><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____             |  |   |  |   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |  |   |  |   |  |
| 19A. DATE OF OPERATION   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br>No   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>October 26,</u> 19 <u>69</u> to <u>October 31,</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>October 31,</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |   |  |   |  |
| 23A. SIGNATURE<br><i>R. Corpus, M.D.</i>   |  |   |  | 23B. DATE SIGNED<br>10-31-69  |  |
| 23C. PHYSICIAN'S NAME (Type)<br>Raymundo R. Corpus, M.D.   |  |   |  | 23D. ADDRESS<br>1514 Division Street Balto., Maryland   |  |
| 24A. BURIAL CREMATION REMOVAL (Specify)<br>Burial  |  | 24B. DATE<br>11/6/69  |  | 24C. NAME OF CEMETERY or CREMATORY<br>Mt Auburn Cemetery  |  |
| 24D. LOCATION<br>Baltimore M   |  | 24E. NAME OF REGISTRAR<br>Robert E. Taber, M.D.   |  | 24F. FUNERAL DIRECTOR<br>Adolphus Halstead  |  |
| 24G. DATE REC'D BY HEALTH DEPT.<br>NOV 6 1969  |  | 24H. NAME OF REGISTRAR<br>Robert E. Taber, M.D.   |  | 24I. ADDRESS<br>1206 W north AVE  |  |

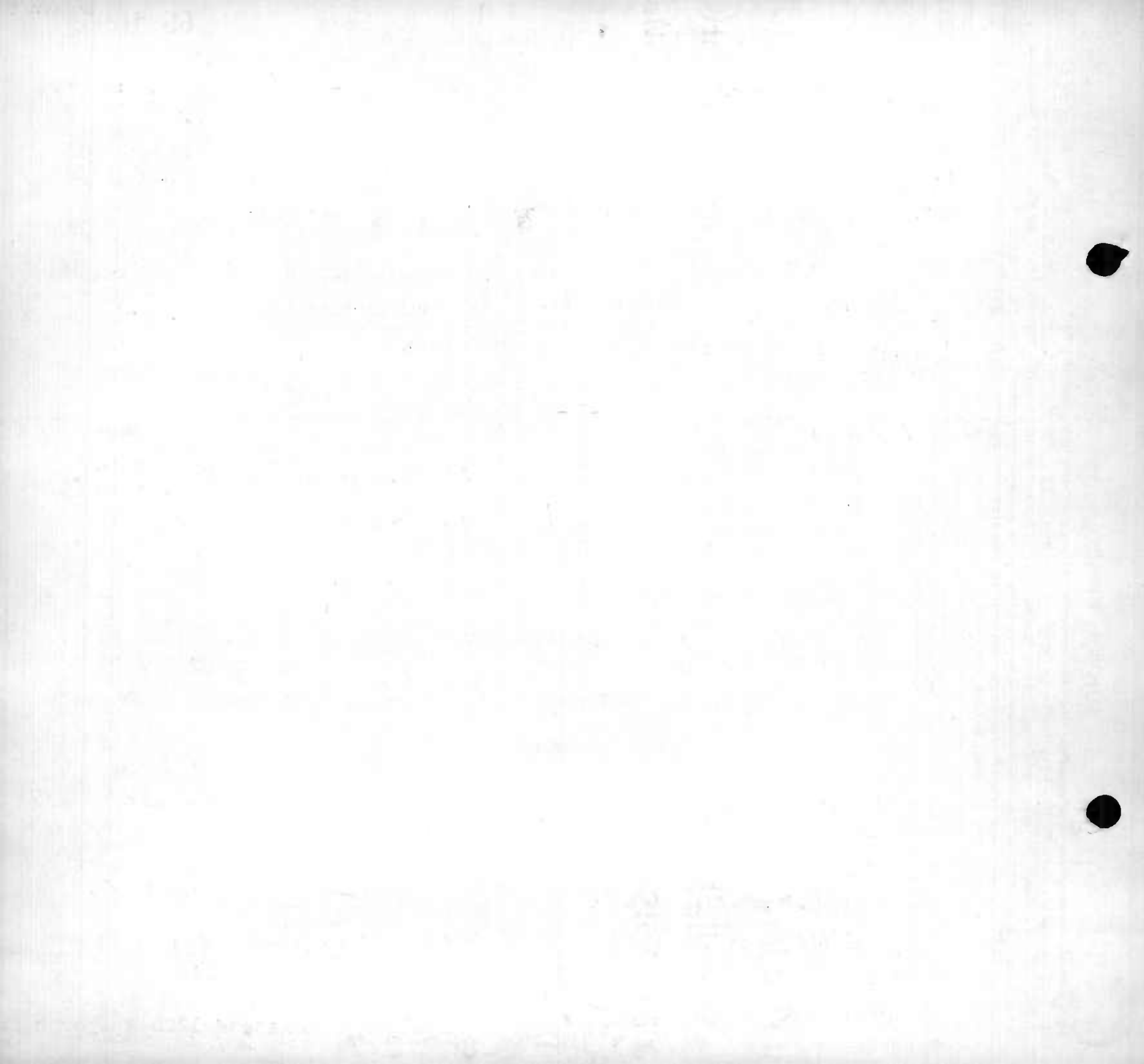




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                         |  |   | REG. NO. <b>69 10952</b>   |   |
|---|-------------------------|--|---|--|---|
| BIRTH NO. <b>69 10952</b>   |                         | CERTIFICATE OF DEATH   |   |  |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>John Joyner</b>   |                         |  | 2. DATE AND HOUR OF DEATH<br><b>10-31-69</b>   <b>3:30</b> P. M.  |  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                         |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>90 Bolton Hill Nursing &amp; Convalescent Center</b>   |                         |  | C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |                         |  | E. STREET AND NUMBER<br><b>1307 Saratoga Street (west)</b>  |  |   |
| 5. SEX<br><b>Male</b>   | 6. RACE<br><b>Negro</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1903</b>   | 9. AGE (In years lost birthday)<br><b>66</b>                             | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>   |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>North Carolina</b>       |   |
| 13. FATHER'S NAME<br><b>John Sidney Joyner</b>  |                         |  | 14. MOTHER'S MAIDEN NAME<br><b>Lettie</b>   |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |                         | 16. SOCIAL SECURITY NO.<br><b>246-30-3829</b>  |   | 17. INFORMANT<br><b>Mrs</b>  |   |
| 18. <b>I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode at dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>162.1 I</b><br><b>CAUSE OF DEATH</b><br><b>with metastases</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                         | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>Bronchogenic Carcinoma</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____         |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Several months.</b>   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                         |  |   |  |   |
| 19A. DATE OF OPERATION<br><b>0</b>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No) <b>No</b>                                      |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |   | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10-29-1969</b> to <b>10-31-1969</b> , that (I) (we) last saw the deceased alive on <b>10-31-1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                         |  |   |  |   |
| 23A. SIGNATURE<br><b>E. Ellsworth Cook</b> DEGREE   |                         |  |   | 23B. DATE SIGNED<br><b>11-1-69</b>                                       |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>E. E. Ellsworth Cook</b> DEGREE  |                         |  |   | 23D. ADDRESS<br><b>2431 Maryland Ave</b>                                 |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 24B. DATE<br><b>11/9/69</b>  |   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Farmville</b>                   |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>North Carolina</b>  |                         | 25A. DATE OF DEATH<br><b>NOV 8 1969</b>  |   |  |   |
| 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>   |                         | 25C. FUNERAL DIRECTOR<br><b>Adolphus Halstead</b> ADDRESS<br><b>1206 W North Av</b>  |   |  |   |



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 10953

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 10953

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| BIRTH NO.  |  | 1. NAME OF DECEASED<br>(Type or Print) <i>OTIE HERNDON</i>  |  | 2. DATE AND HOUR OF DEATH<br><i>11-4-69</i> <i>5:35</i> A.M.  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY <i>BALTIMORE</i>                      |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>BALTIMORE CITY HOSPITALS</i><br><i>4940 Eastern Avenue</i><br><i>Baltimore, Maryland 21224</i>  |  |   |  | C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  |
| 5. SEX <i>Male</i> 6. RACE <i>White</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |   |  | 8. DATE OF BIRTH <i>2-24-03</i> 9. AGE (In years last birthday) <i>66</i>   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Detective</i>   |  | 10B. KIND OF BUSINESS OR INDUSTRY <i>Agency</i>   |  | 11. BIRTHPLACE (State or foreign country) <i>West Virginia</i>  |  |
| 13. FATHER'S NAME <i>William Herndon</i>   |  |   |  | 14. MOTHER'S MAIDEN NAME <i>Emma</i>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO. <i>233-28-4594A</i>   |  | 17. INFORMANT <i>BCH: Records</i> ADDRESS <i>4940 Eastern Avenue Baltimore, Maryland 21224</i>  |  |
| 18. <i>4-10-9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  |   |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Prob myocardial infarction ~ 1 hr</i><br>(B) <i>Atherosclerotic Heart Disease</i><br>(C) |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |   |  |   |  |
| 19A. DATE OF OPERATION <i>0</i>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No) <i>no</i>   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)          |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (H) (this hospital) attended the deceased from <i>11-4</i> 19 <i>69</i> to <i>11/4</i> 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>DOA 11/4 19 69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. |  |   |  |   |  |
| 23A. SIGNATURE <i>James T. Corkins MD</i> DEGREE   |  |   |  | 23B. DATE SIGNED <i>11/4/69</i>   |  |
| 23C. PHYSICIAN'S NAME (Type) <i>James T. Corkins M.D.</i> DEGREE   |  |   |  | 23D. ADDRESS <i>BALTIMORE CITY HOSPITALS 21224 4940 Eastern Avenue Baltimore, Maryland</i>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Removal</i>  |  | 24B. DATE <i>Nov 4/69</i>   |  | 24C. NAME OF CEMETERY or CREMATORY <i>Frankford</i>   |  |
| 24D. LOCATION (City, town, or county) <i>W Va</i>  |  | 24E. LOCATION (City, town, or county) <i>W Va</i>   |  | 24F. LOCATION (City, town, or county) <i>W Va</i>   |  |
| 25A. DATE REC'D BY HEALTH DEPT. <i>NOV 6 1969</i>  |  | 25B. NAME OF REGISTRAR <i>W E. Taylor MD</i>  |  | 25C. FUNERAL DIRECTOR <i>Philip Herring Sons</i> ADDRESS <i>2024</i>  |  |

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C. 520

69 10954

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 10954

BIRTH NO.

REG. NO.

|   |  |  |  |
|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>JOSEPH G. CAMAS</b>  |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br><b>November 1st. 1969</b>  |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>UNION MEMORIAL HOSPITAL (DOA)</b>  |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>November 1, 1969 12:20 P.M.</b>   |  |
| 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>2758</b>   |  | C. CITY OR TOWN<br><b>Baltimore</b>  |  |
| 6. SEX<br><b>Male</b>   |  | 7. RACE<br><b>White</b>  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 9. DATE OF BIRTH<br><b>March 5</b>  |  | 10. AGE (In years last birthday)<br><b>45</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Bradford</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  |
| 13. FATHER'S NAME<br><b>R. Laco Leamas</b>  |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Managerial</b>  |  |
| 15. MOTHER'S MAIDEN NAME<br><b>Mary Mongillo</b>  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  |  |
| 17. SOCIAL SECURITY NO.<br><b>208-16-7628</b>   |  | 18. INFORMANT<br><b>Mr. Leo Barney</b>   |  |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Arteriosclerotic Cardiovascular Disease</b>  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |  | (B) DUE TO, OR AS A CONSEQUENCE OF:  |  |
| 20A. DATE OF OPERATION<br><b>11/2/69</b>  |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 21. AUTOPSY? (Yes or No)<br><b>no</b>   |  | 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |
| 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?   |  |
| 22D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)<br><b>11/2/69</b>  |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |
| 22F. HOW DID INJURY OCCUR?  |  | 23.  |  |
| I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |
| ACTUAL SIGNATURE<br><b>Ronald N. Kornblum</b><br>EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED <b>11/2/69</b> |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Removal</b>  |  | 24B. DATE<br><b>Nov 2/69</b>   |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>St. Bernard</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore Pa</b>   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 6 1969</b>  |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Fahey, M.D.</b>   |  |
| 25C. FUNERAL DIRECTOR<br><b>Philip Herwig Sons</b>  |  | ADDRESS<br><b>2024 Calverton St</b>  |  |

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "valley", "eastern", and "academy" are faintly visible.]



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65-12910 69 10955  |                     |  |                                    | BALTIMORE CITY HEALTH DEPARTMENT   |  | X REG. NO. 69 10955   |  |
|--|---------------------|--|------------------------------------|--|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>THOMAS, SEAN RICHARD</b>   |                     |  |                                    | 2. DATE AND HOUR OF DEATH<br><b>11-5-69</b>  |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><b>42 SINAI Hospital</b>   |                     |  |                                    | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD</b> B. COUNTY <b>BALTO. CO.</b> C. CITY OR TOWN <b>21234 BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1712 KENNOWAY ROAD</b> |  |   |  |
| 5. SEX<br><b>M</b>   | 6. RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5-29-65</b> | 9. AGE (In years last birthday)<br><b>4</b>  | If Under 1 Yr. Months: Days: Hours: Min. |   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>   |                     | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>   |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>BALTIMORE, Md.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                           |  |
| 13. FATHER'S NAME<br><b>Richard S. THOMAS</b>  |                     |  |                                    | 14. MOTHER'S MAIDEN NAME<br><b>ROSEMARY KLAND</b>  |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>  |                     | 16. SOCIAL SECURITY NO.<br><b>NONE</b>   |                                    | 17. INFORMANT ADDRESS<br><b>RICHARD S. THOMAS (SAME)</b>   |  |   |  |
| 18. <b>466 X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>CARDIAC failure</b>   |                     |  |                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>7 days</b>  |  |   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slotting the UNDERLYING CONDITION last.<br><b>CNS Damage</b>   |                     |  |                                    | DUE TO, OR AS A CONSEQUENCE OF:<br><b>AC. Tracheobronchitis</b>  |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |                     |  |                                    |  |  |   |  |
| 19A. DATE OF OPERATION<br><b>11-28-69</b>  |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Ac. Tracheobronchitis</b>   |                                    | 20A. AUTOPSY? (Yes or No)<br><b>No</b>   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?    |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |   |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                                    | 21F. HOW DID INJURY OCCUR?   |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10-27</b> 19 <b>69</b> to <b>11-5</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>11-5</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                     |  |                                    |  |  |   |  |
| 23A. SIGNATURE<br><b>L.A. Torres</b>   |                     |  |                                    | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>  |  | 23B. DATE SIGNED<br><b>11-5-69</b>                                      |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>L.A. TORRES</b>   |                     |  |                                    | 23D. ADDRESS<br><b>SINAI Hosp.</b>   |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Rem. Burial</b>   |                     | 24B. DATE<br><b>11-7-69</b>  |                                    | 24C. NAME OF CEMETERY or CREMATORY<br><b>Fairview Cemetery</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>Westfield N. J.</b> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 6 1969</b>   |                     | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>  |                                    | 25C. FUNERAL DIRECTOR ADDRESS<br><b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Baltimore, Md. 21212</b>   |  |   |  |

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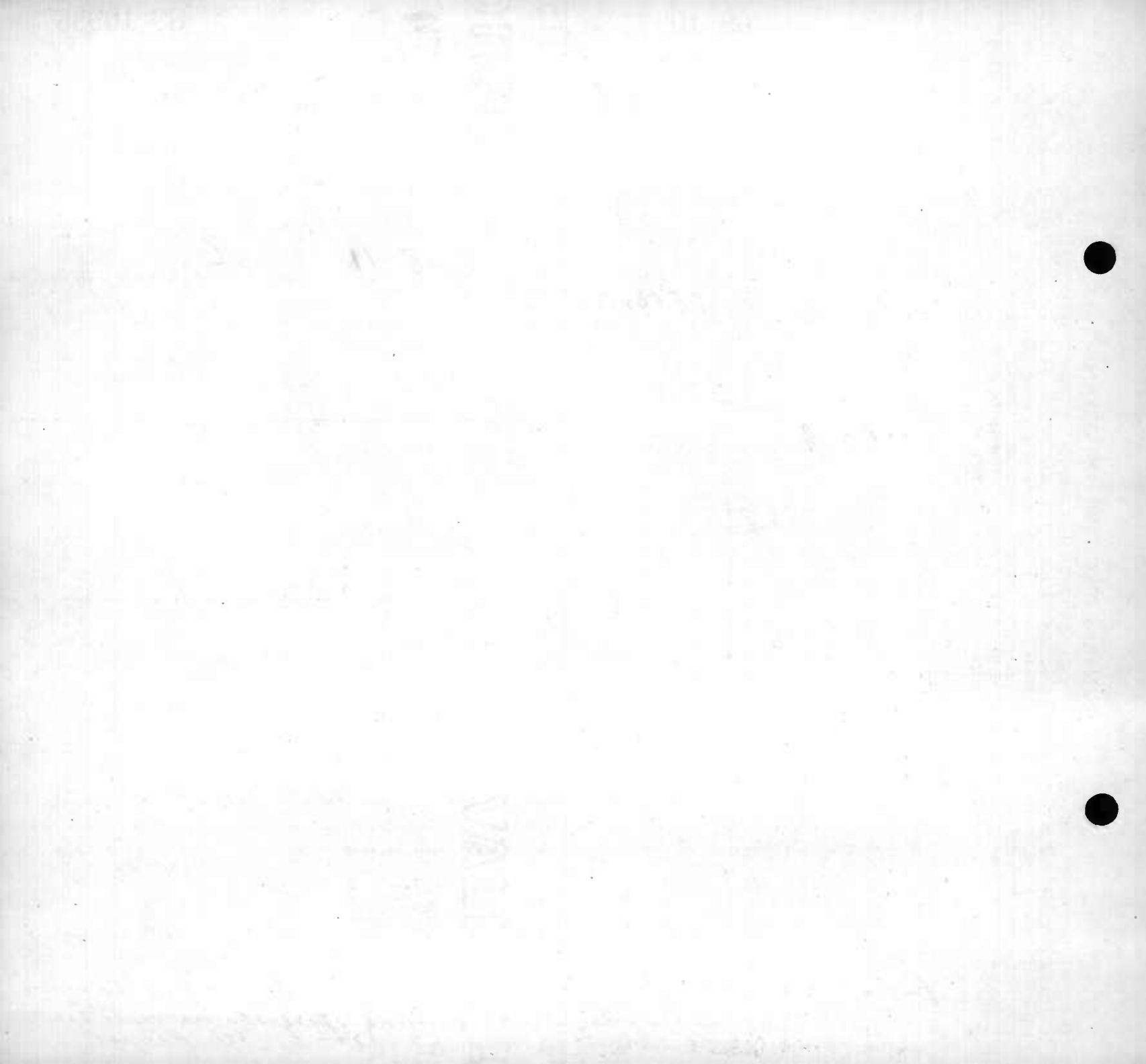
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. **69 10956**

|  |                     |   |   |   |  |
|--|---------------------|---|---|---|--|
| BIRTH NO.  |                     | 1. NAME OF DECEASED<br>(Type or Print) <b>ETHEL H. KUNKOSKI</b>   |   | 2. DATE AND HOUR OF DEATH<br><b>11-2-69 12<sup>10</sup> P. M.</b>     |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                     |   | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>2401</b>   |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>43 SOUTH BALTIMORE GEN HOSP.</b>  |                     |   | C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |  |
| E. STREET AND NUMBER <b>1156 COOKSIE ST</b>  |                     |   |   |   |  |
| 5. SEX<br><b>F</b>   | 6. RACE<br><b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>9-28-11</b>                                    | 9. AGE (In years lost birthday) <b>58</b>                                |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Clerk</b>  |                     | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>J.F. Obrecht Co.</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>SCOTLAND</b>          | 12. CITIZEN OF WHAT COUNTRY?<br><b>Scot/Am</b>                           |
| 13. FATHER'S NAME<br><b>GLEN WOOD</b>  |                     |   | 14. MOTHER'S MAIDEN NAME<br><b>MARGARET Fisherman</b>   |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                     | 16. SOCIAL SECURITY NO.<br><b>212-09-9345</b>   |   | 17. INFORMANT<br><b>CHART.</b>  |  |
| 18. <b>412.21</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) sloting the UNDERLYING CONDITION lost.<br><br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |                     |   | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CEREBRAL HEMORRAGE</b><br>(B) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____ |   |  |
| 19A. DATE OF OPERATION<br><b>0</b>   |                     |   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                     |   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                     |   | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |   | 21F. HOW DID INJURY OCCUR?   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>11/1</b> 19 <b>69</b> to <b>11/2</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>11/2</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                     |   |   |   |  |
| 23A. SIGNATURE<br><b>CHARLES A. TOLENTINO</b>  |                     |   | 23B. DATE SIGNED<br><b>11/2/69</b>  |   | 23C. ADDRESS<br><b>SOUTH BALT. GEN HOSP.</b>                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                     |   | 24B. DATE<br><b>11/6/69</b>   |   | 24C. NAME OF CEMETERY or CREMATORY<br><b>Holy Rosary Cemetery</b>        |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>  |                     |   |   |   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 6 1969</b>   |                     | 25B. NAME OF REGISTRAR<br><b>John E. Taylor, M.D.</b>   |   | 25C. FUNERAL DIRECTOR<br><b>Charles L. Stevens Funeral Home, Inc.</b> |  |
|  |                     |   |   | ADDRESS<br><b>1501 E. Fort Avenue</b>                                 |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| 69 10957 CERTIFICATE OF DEATH   |                  |  |   | REG. NO. 69 10957   |   |
|---|------------------|--|---|---|---|
| BIRTH NO.   |                  | 1. NAME OF DECEASED<br>(Type or Print) <i>ROSA LIA (Rose) KLOSEK</i>   |   | 2. DATE AND HOUR OF DEATH<br><i>11-4-69 10:00 P.M.</i>  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><i>South BALTIMORE GENERAL HOSPITAL</i>  |                  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <i>BALTIMORE</i> B. COUNTY <i>M.D.</i> C. CITY OR TOWN <i>U.S.A.</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>1409 REYNOLDS ST.</i> |   |   |
| 5. SEX <i>F</i>   | 6. RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>4-15-88</i>   | 9. AGE (In years last birthday) <i>81</i>   | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>HOME MAKER</i>  |                  | 10B. KIND OF BUSINESS OR INDUSTRY <i>—</i>   |   | 11. BIRTHPLACE (State or foreign country)<br><i>POLAND</i>  |   |
| 13. FATHER'S NAME<br><i>JOSEPH KALINOWSKI</i>   |                  |  | 14. MOTHER'S MAIDEN NAME<br><i>JOSEPHINE UKKIDOWN</i>   |   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>No</i>   |                  | 16. SOCIAL SECURITY NO.<br><i>213-50-8292</i>  |   | 17. INFORMANT ADDRESS<br><i>STELLA DOETZLER - DAUGHTER</i>  |   |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,<br><br><i>II</i><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><br>19A. DATE OF OPERATION <i>11-4-69</i> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i> 20A. AUTOPSY? (Yes or No) <i>—</i> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>—</i> |                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |   |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                          |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |   | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) (this hospital) attended the deceased from <i>11-3-69</i> to <i>11-4-69</i> , that (I) (we) last saw the deceased alive on <i>11-4-69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.   |                  |  |   |   |   |
| 23A. SIGNATURE<br><i>Lilia C. Baldonado M.D.</i> DEGREE <i>Attending Phys.</i> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>   |                  |  |   | 23B. DATE SIGNED<br><i>11-4-69</i>  |   |
| 23C. PHYSICIAN'S NAME (Type)<br><i>LILIA C. BALDONADO M.D.</i> DEGREE   |                  |  |   | 23D. ADDRESS<br><i>South Balt. Gen. Hosp. 3001 S. Harwood St.</i>                                 |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |                  | 24B. DATE<br><i>11/8/69</i>  |   | 24C. NAME OF CEMETERY or CREMATORY<br><i>Holy Rosary Cemetery</i>                                 |   |
|   |                  |  |   | 24D. LOCATION (City, town, or county) (State)<br><i>Baltimore, Maryland</i>                       |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>NOV 6 1969</i>  |                  | 25B. NAME OF REGISTRAR<br><i>Robert E. Tabor, M.D.</i>   |   | 25C. FUNERAL DIRECTOR ADDRESS<br><i>Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue</i> |   |

1988-11-1

69 10958

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 10958

BIRTH NO.

|  |                         |   |  |
|--|-------------------------|---|--|
| 1. NAME OF DECEASED (Carrollton)<br>(Type or Print)<br><b>Carroll D. Witters</b>   |                         | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> M.  |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>UNIVERSITY HOSPITAL</b>   |                         | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>November 3, 1969 12:30 P.M.</b>  |  |
| 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>   |                         |   |  |
| 6. SEX<br><b>Male</b>  | 7. RACE<br><b>White</b> | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |
| 9. DATE OF BIRTH<br><b>Nov. 29, 1886</b>   |                         | 10. AGE (In years lost birthday) <b>82</b><br>If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b>  |                         | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>  |                         | 14B. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |  |
| 14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                         | 17. SOCIAL SECURITY NO.<br><b>219-54-3475J</b>  |  |
| 16. INFORMANT<br><b>Mrs. Wm. E. Chamberlain</b>  |                         | ADDRESS<br><b>1214 Hamblewood Rd</b>  |  |
| 19. CAUSE OF DEATH<br><b>E 8871</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>Subdural Hematoma</b>  |                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Peritonitis due to perforated duodenal ulcer</b><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF: |  |
| 20A. DATE OF OPERATION<br><b>2</b>   |                         | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                         | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Hospital</b>   |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br><b>Spring Grove State Hospital</b>   |                         | 22F. HOW DID INJURY OCCUR?<br><b>Subject fell in hospital</b>   |  |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)<br><b>Oct. 25, 1969 Unk.</b>   |                         | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D.<br>EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED <b>11/5/69</b> |                         |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 24B. DATE<br><b>11-7-1969</b>   |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Greenmount Cemetery</b>   |                         | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 6 1969</b>   |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Barber, M.D.</b>   |  |
| 25C. FUNERAL DIRECTOR<br><b>H. W. Jenkins &amp; Sons Co.</b>   |                         | ADDRESS<br><b>21212 4905 York Road Balto., Md.</b>  |  |

11/13/69 - Letter from ~~Chief~~ Medical Examiner, Dr. Ronald  
N. Kornblum, Assist.

Correction form from funeral director.

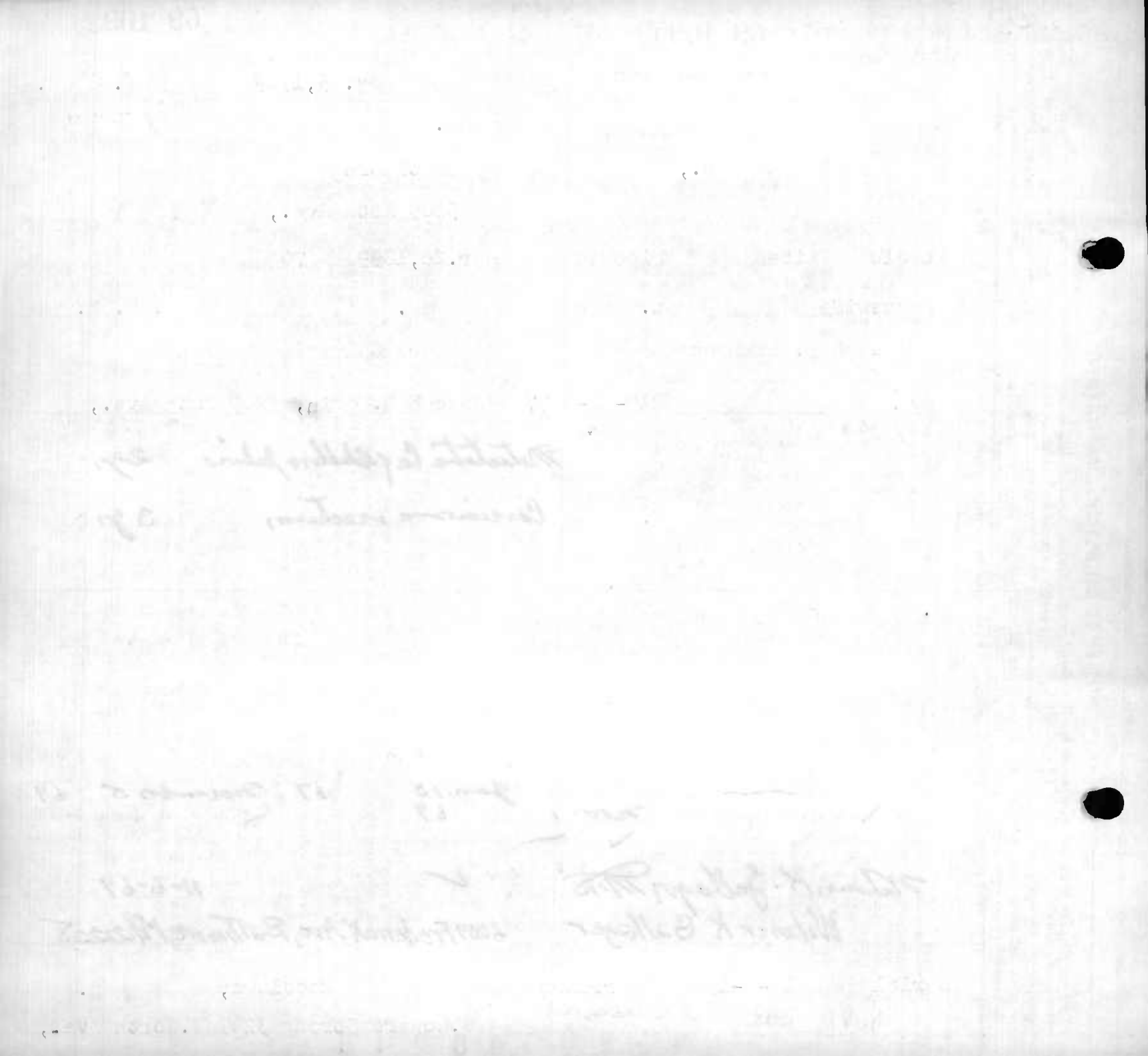
*[Handwritten signature]*  
*[Handwritten signature]*



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 69 10959   |  |  |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | Registered No. 69 10959  |  |
|--|--|--|--|---|--|--|--|
| M.E. CASE NO.  |  |  |  | 1. NAME OF DECEASED   |  | 2. DATE AND HOUR OF DEATH  |  |
|  |  |  |  | Lucy Mae Cain   |  | Nov. 5, 1969 1.00 P.M.   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  |  |  |  | A. STATE B. COUNTY  |  |  |  |
| 5209 Muth Ave.,  |  |  |  | Md.   |  | 2833   |  |
| 5. SEX   |  |  |  | 6. RACE   |  | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)                |  |
| Female   |  |  |  | White   |  | Widowed  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |  |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)                            |  |
| Housewife  |  |  |  | At. Home  |  | Md.  |  |
| 13. FATHER'S NAME  |  |  |  | 14. MOTHER'S MAIDEN NAME  |  | 12. CITIZEN OF WHAT COUNTRY?   |  |
| Joseph B. Simmons  |  |  |  | Clara Galvin  |  | U. S. A.   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |  |  |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |
| no   |  |  |  | 219-22-2677   |  | Joseph R. Cain, 5209 Muth Ave.,                                      |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  |  |  |  | CAUSE OF DEATH  |  | INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| 1. 154.1 I   |  |  |  | Metastatic Carcinoma of Bladder & Pelvis  |  | 2 yrs.   |  |
| 2. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |  |  |  | (B) Carcinoma rectum  |  | 3 yrs.   |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |  |  |   |  |  |  |
| 19A. DATE OF OPERATION   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  |   |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |  |  |  |
|  |  |  |  |   |  |  |  |
| 21D. TIME OF INJURY (APPROX.)  |  | 21E. INJURY OCCURRED   |  | 21F. HOW DID INJURY OCCUR?  |  |  |  |
|  |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |  |   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 10 1967 to November 5 1969, that (I) (we) last saw the deceased alive on Nov. 1 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 23A. SIGNATURE   |  |  |  | 23B. DATE SIGNED  |  |  |  |
| Wilmer K. Gallagher M.D.   |  |  |  | 11-6-69   |  |  |  |
| 23C. PHYSICIAN'S NAME (Type)   |  |  |  | 23D. ADDRESS  |  |  |  |
| Wilmer K. Gallagher M.D.   |  |  |  | 6209 Frederick Ave, Baltimore, Md. 21228  |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |  | 24B. DATE  |  | 24C. NAME OF CEMETERY or CREMATORY  |  | 24D. LOCATION (City, town, or county) (State)                        |  |
| Burial   |  | 11-8-1969  |  | Lorraine Park   |  | Woodlawn, Md.  |  |
| 25A. DATE REC'D BY HEALTH DEPT.  |  | 25B. NAME OF REGISTRAR   |  | 25C. FUNERAL DIRECTOR   |  | ADDRESS  |  |
| NOV 6 1969   |  | Robert E. Galley, M.D.   |  | G. Howard Strong 3207 W. North Ave.,  |  |  |  |





R-125

BALTIMORE CITY HEALTH DEPARTMENT

69 10960

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 10960

REG. NO.

BIRTH NO.

|  |                         |  |  |  |  |
|--|-------------------------|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>MARY L. (ROBINSON) Robison</b>   |                         | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> <b>Nov. 1 1969</b>                                      |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>November 1, 1969 8:45 P.</b>  |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>ST. AGNES HOSPITAL (DOA)</b>  |                         | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Howard</b>                |  | 6. CITY OR TOWN <b>Woodbine</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 6. SEX<br><b>Female</b>  | 7. RACE<br><b>White</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. DATE OF BIRTH<br><b>July 10, 1915</b>   |  |
| 10. AGE (In years lost birthday) <b>54</b>   |                         | 11. BIRTHPLACE (State or foreign country)<br><b>MD.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>FRANK HERMAN JAMES</b>   |                         | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>BAKERY CLERK MAR. RETAIL BAKERY</b>                     |  | 15. MOTHER'S MAIDEN NAME<br><b>MADLANA MARY STEWART</b>  |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or doles of service)<br><b>No</b>   |                         | 17. SOCIAL SECURITY NO.<br><b>214-01-9606</b>  |  | 18. INFORMANT ADDRESS<br><b>Joseph O. Robison Woodbine Md</b>  |  |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Multiple Traumatic Injuries</b>   |                         | CAUSE OF DEATH<br><b>Multiple Traumatic Injuries</b>   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |                         | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:   |  |  |  |
|  |                         | (B) DUE TO, OR AS A CONSEQUENCE OF:  |  |  |  |
|  |                         | (C) DUE TO, OR AS A CONSEQUENCE OF:  |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                         |  |  |  |  |
| 20A. DATE OF OPERATION<br><b>2</b>   |                         | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 21. AUTOPSY? (Yes or No)<br><b>yes</b>   |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                         | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Street</b>  |  | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br><b>Rte. 40, 3000 ft. W. of Rt. 32</b>          |  |
| 22D. TIME (Month) (Day) (Year) (Hour) (APPROX.) <b>11-1-69 7:45 P.</b>   |                         | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                     |  | 22F. HOW DID INJURY OCCUR?<br><b>Driver in auto-auto collision</b>   |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> M.D.<br>EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED <b>11/2/69</b> |                         |  |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                         | 24B. DATE<br><b>11/5/69</b>  |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Louisa PK. Cem.</b>   |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>BALTIMORE MD</b>   |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 6 1969</b>   |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher, M.D.</b>  |  |
| 25C. FUNERAL DIRECTOR<br><b>E. Mac Nabb</b>  |                         | 25D. ADDRESS<br><b>301 Frederick Rd Balt Md 21228</b>  |  |  |  |

00001 43

UNITED STATES DEPARTMENT OF HEALTH

NO 10860



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |  |  |
|---|--|--|--|
| BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. <b>69 10961</b>   |  |
| BIRTH NO. <b>69 10961</b>   |  | X  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Parker, Edna Scott</b>  |  | 2. DATE AND HOUR OF DEATH<br><b>11/3/69 1:35 P.M.</b>  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>Balto.</b>                     |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>38 University of Maryland Hospital</b>   |  | C. CITY OR TOWN <b>Baltimore, Md.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                         |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |  | E. STREET AND NUMBER   |  |
| 5. SEX <b>Female</b>  | 6. RACE <b>white</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>2/28/08</b>                                      |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>  | 9. AGE (in years last birthday) <b>61</b>                            |
| 11. BIRTHPLACE (State or foreign country)<br><b>Washington, D.C.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>John J. Fegan</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Edna Scott</b>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO. <b>--</b>  |  |
| 17. INFORMANT<br><b>Daniel Parker Adelphi, Maryland</b>   |  | ADDRESS<br><b>9004 Riggs Road</b>  |  |
| 18. <b>599.01</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Chronic Renal failure</b><br><b>Chronic pyelonephritis</b>  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Septicemia sec to urinary tract infection</b><br><b>Pneumonia</b>  |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <b>Bacterial pneumonia</b>                             |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |  |  |
| 19A. DATE OF OPERATION<br><b>10/31/69</b>   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20A. AUTOPSY? (Yes or No)  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10/31/69</b> 19 to <b>11/3/69</b> 1969 that (I) (we) last saw the deceased alive on <b>11/3/69</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |
| 23A. SIGNATURE<br><b>Victor Hernandez, M.D.</b>   |  | 23B. DATE SIGNED   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Victor Hernandez</b>   |  | 23D. ADDRESS<br><b>University of Maryland Hospital</b>   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Cremation</b>  |  | 24B. DATE<br><b>11/6/69</b>  |  |
| 24C. NAME OF CEMETERY OR CREMATORY<br><b>Lees Crematory</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>Washington D.C.</b>  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 1969</b>  |  | 25B. NAME OF REGISTRAR<br><b>John W. Lees Sons, Co. Wash. DC</b>   |  |
| 25C. FUNERAL DIRECTOR   |  | ADDRESS  |  |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 10962

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 10962

|   |                         |   |   |  |   |
|---|-------------------------|---|---|--|---|
| BIRTH NO.   |                         | 1. NAME OF DECEASED<br>(Type or Print) <u>MCCULLOUGH LEROY Samuel</u>   |   | 2. DATE AND HOUR OF DEATH<br><u>11-5-69</u> <u>3:40 P.M.</u>             |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                         |   | 4. USUAL RESIDENCE (Where deceased lived, if institutional residence before admission)<br>A. STATE <u>MD</u> B. COUNTY <u>1607</u>  |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>46 LUTHERAN HOSPITAL</u>   |                         |   | C. CITY OR TOWN<br><u>BALTIMORE</u>   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|   |                         |   | E. STREET AND NUMBER<br><u>3320 POPLAR ST</u>   |  |   |
| 5. SEX<br><u>MALE</u>   | 6. RACE<br><u>NEGRO</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><u>7-4-88</u>  | 9. AGE (In years)<br><u>81</u>  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>RETIRED</u>   |   | 11. BIRTHPLACE (State or foreign country)<br><u>N.C., Charlotte</u>      |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |                         | 13. FATHER'S NAME<br><u>Elijah McCullough</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>Nora McCullough</u>                       |   |
| 15. Was Deceased Ever in U. S. Armed Forces?<br>(Yes, no or unknown) (If yes, give war or dates of service)<br><u>NO.</u>   |                         | 16. SOCIAL SECURITY NO.<br><u>218-16-3739A</u>  |   | 17. INFORMANT<br><u>Mrs. Lillian Jones</u>                               |   |
|   |                         |   |   | ADDRESS<br><u>3320 Poplar St.</u>  |   |
| 18. <u>486X I</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                     |                         |   | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><u>?</u><br><br>(B) <u>Pulminating Pneumonia?</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) _____ |  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |                         |   |   |  |   |
| 19A. DATE OF OPERATION<br><u>0</u>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)  |   |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)  |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>   |   | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <u>11/4/69</u> 19 <u>69</u> to <u>11/5</u> 19 <u>69</u> , that (I) <u>✓</u> last saw the deceased alive on <u>11/5/69</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>✓</u> (We) <u>✓</u> (did not) view the body after death. |                         |   |   |  |   |
| 23A. SIGNATURE<br><u>Zaheer Ahmad Khan</u>  |                         |   |   | 23B. DATE SIGNED   |   |
| 23C. PHYSICIAN'S NAME (Type)<br><u>ZAHEER AHMAD KHAN</u>  |                         |   |   | 23D. ADDRESS<br><u>90 LUTHERAN HOSPITAL</u>                              |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |                         | 24B. DATE<br><u>11/10/69</u>  |   | 24C. NAME of CEMETERY or CREMATORY<br><u>Mt. Auburn Cem.</u>             |   |
| 24D. LOCATION<br><u>Baltimore, Maryland</u>   |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 6 1969</u>  |   | 25B. NAME OF REGISTRAR<br><u>Robert E. Taylor, M.D.</u>                  |   |
| 25C. FUNERAL DIRECTOR<br><u>Morton &amp; Dyett F.H.</u>   |                         | 25D. ADDRESS<br><u>1701 Lucas St.</u>   |   |  |   |

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                  |   |   |   |   |   |                                     |
|--|------------------|---|---|---|---|---|-------------------------------------|
| B-600  |                  | 69 10963  |   | BALTIMORE CITY HEALTH DEPARTMENT  |   | X REG. NO. 69 10963   |                                     |
| BIRTH NO.  |                  |   |   | 1. NAME OF DECEASED<br>(Type or Print) BERRY, FLOY  |   |   |                                     |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                  |   |   | 2. DATE AND HOUR OF DEATH<br>11-05-69 1 2:10 P.M.   |   |   |                                     |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>ST. AGNES HOSP.<br>WILKENS & CATON AVE. BALTO.MD.21228  |                  |   |   | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE MARYLAND B. COUNTY BALTO.CO. 5300 |   |   |                                     |
|  |                  |   |   | C. CITY OR TOWN<br>BALTIMORE  |   | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                     |
|  |                  |   |   | E. STREET AND NUMBER<br>1450 BARRETT RD 21207   |   |   |                                     |
| 5. SEX<br>FEMALE   | 6. RACE<br>WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>08-12-82                      | 9. AGE (In years last birthday)<br>87   | 10. Under 1 Yr. Months: Days: Hours: Min.                     | 11. Under 24 Hrs. Min.  |                                     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>RETIRED - MUSIC TEACHER   |                  |   | 10B. KIND OF BUSINESS OR INDUSTRY                 |   | 11. BIRTHPLACE (State or foreign country)<br>ARKANSAS         |   | 12. CITIZEN OF WHAT COUNTRY?<br>USA |
| 13. FATHER'S NAME<br>CHARLES MEYERS DEC 'D   |                  |   | 14. MOTHER'S MAIDEN NAME<br>MARY M. FOSTER DEC 'D |   |   |   |                                     |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO   |                  |   | 16. SOCIAL SECURITY NO.<br>430-62-9291            |   | 17. INFORMANT<br>ST. AGNES RECORD ROOM - WILKENS & CATON AVE. |   |                                     |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.)<br>INTRACEREBRAL BLEEDING.<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>H.ASCVD.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |                  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |   |                                     |
| 19A. DATE OF OPERATION<br>2  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)<br>YES  |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>YES                   |                                     |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |   |                                     |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX.)   |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |   | 21F. HOW DID INJURY OCCUR?  |   |   |                                     |
| 22. I certify that (X) (this hospital) attended the deceased from 11-03-69 19 to 11-05 19 69 that (X) (we) last saw the deceased alive on 11-05 1969 and that (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.   |                  |   |   |   |   |   |                                     |
| 23A. SIGNATURE<br><i>Alejandro Mejia</i><br>ALEJANDRO MEJIA MD.  |                  |   |   | 23B. DATE SIGNED<br>11-05-69  |   | 23C. PHYSICIAN'S NAME (Type)<br>ALEJANDRO MEJIA MD.   |                                     |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial   |                  | 24B. DATE<br>11/8/69  |   | 24C. NAME OF CEMETERY OR CREMATORY<br>Bready Cemetery   |   | 24D. LOCATION (City, town, or county) (State)<br>Dardanell, Arkansas                          |                                     |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 7 1969  |                  | 25B. NAME OF REGISTRAR<br>Robert E. Taylor  |   | 25C. FUNERAL DIRECTOR<br>Witzke, 4101 Edmondson Ave.,   |   | 25D. ADDRESS<br>21229   |                                     |

INTERNATIONAL REPORT

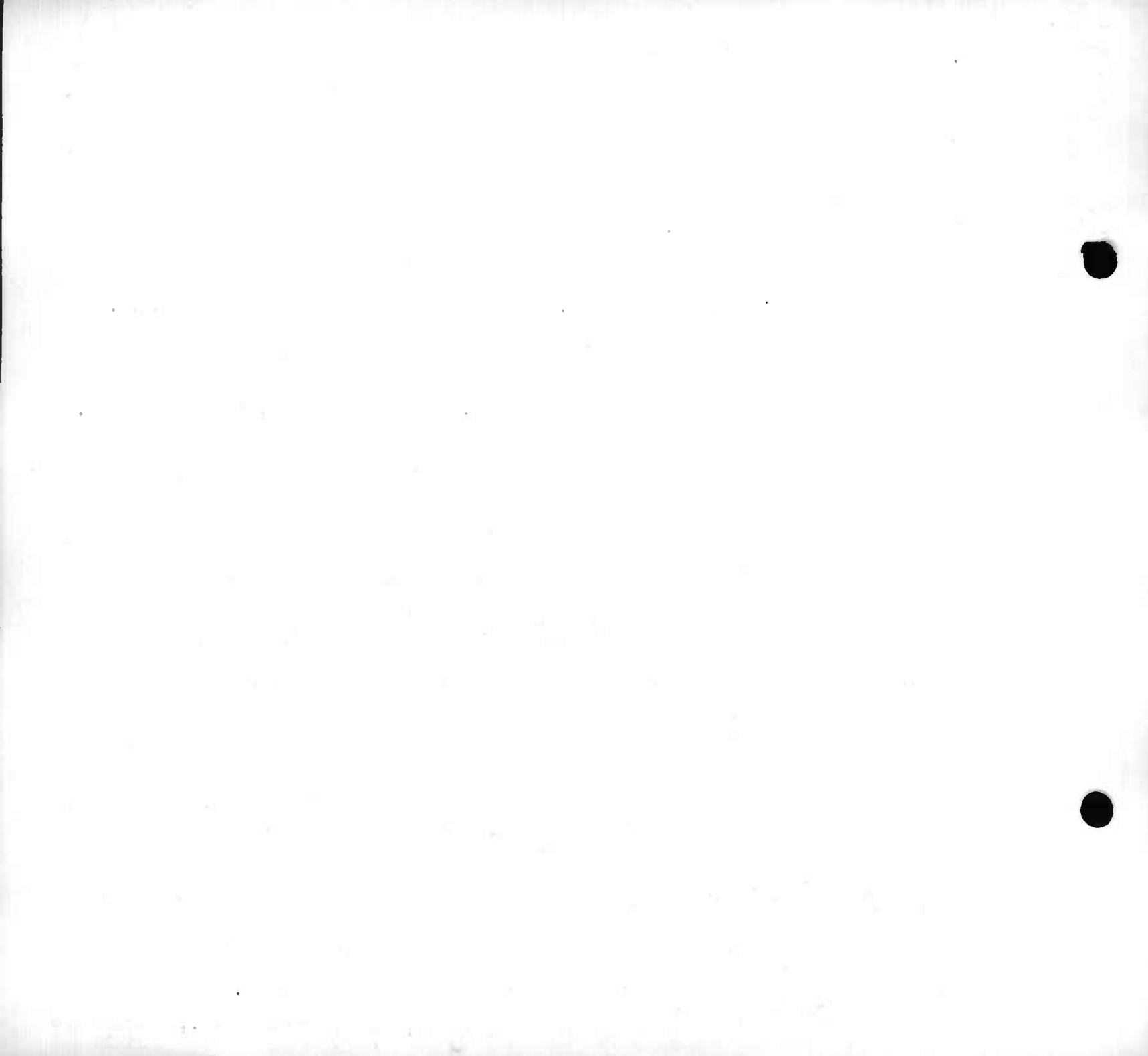
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |  |  |   | REG. NO. <span style="font-size: 1.2em;">69 10964</span>   |  |
|---|--|--|---|--|--|
| <p style="font-size: 1.5em; margin: 0;">S-534</p> <p style="font-size: 1.2em; margin: 0;">69 10964</p> <p style="margin: 0;">BIRTH NO.</p>  |  | CERTIFICATE OF DEATH   |   |  |  |
| <p>1. NAME OF DECEASED<br/>(Type or Print)</p> <p style="font-size: 1.1em;">SCHINDHELM, Elizabeth</p>   |  |  | <p>2. DATE AND HOUR OF DEATH</p> <p style="font-size: 1.1em;">11/6/69      8:05 A. M.</p>   |  |  |
| <p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p style="font-size: 1.1em;">The Johns Hopkins Hospital</p>   |  |  | <p>4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)</p> <p style="font-size: 1.1em;">Maryland</p>              |  |  |
| <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p style="font-size: 1.1em;">The Johns Hopkins Hospital</p>  |  |  | <p>C. CITY OR TOWN</p> <p style="font-size: 1.1em;">Baltimore</p>   |  | <p>D. INSIDE CITY LIMITS?</p> <p>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>   |
| <p>5. SEX</p> <p style="font-size: 1.1em;">Female</p>   |  |  | <p>6. RACE</p> <p style="font-size: 1.1em;">White</p>   |  | <p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></p> <p>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p> |
| <p>8. DATE OF BIRTH</p> <p style="font-size: 1.1em;">3/29/20</p>  |  |  | <p>9. AGE (In years last birthday)</p> <p style="font-size: 1.1em;">49</p>  |  | <p>If Under 1 Yr. Months Days</p> <p>If Under 24 Hrs. Hours Min.</p>   |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p style="font-size: 1.1em;">Seamstress</p>  |  |  | <p>10B. KIND OF BUSINESS OR INDUSTRY</p> <p style="font-size: 1.1em;">L. Grief &amp; Bros.</p>  |  | <p>11. BIRTHPLACE (State or foreign country)</p> <p style="font-size: 1.1em;">Maryland</p>   |
| <p>12. CITIZEN OF WHAT COUNTRY?</p> <p style="font-size: 1.1em;">U.S.A.</p>   |  |  | <p>13. FATHER'S NAME</p> <p style="font-size: 1.1em;">Warren Edwards</p>  |  |  |
| <p>14. MOTHER'S MAIDEN NAME</p> <p style="font-size: 1.1em;">Elizabeth Kelly</p>  |  |  | <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p style="font-size: 1.1em;">no</p> |  |  |
| <p>16. SOCIAL SECURITY NO.</p>  |  |  | <p>17. INFORMANT ADDRESS</p> <p style="font-size: 1.1em;">Mr. Daniel Schindhelm, 5324 Winner Ave.</p>   |  |  |
| <p>18. CAUSE OF DEATH</p> <p style="font-size: 1.2em;">I</p> <p style="text-align: center;">DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p style="text-align: center;">ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p style="font-size: 1.2em;">(A) IMMEDIATE CAUSE <u>Cardiovascular collapse &amp; arrest</u></p> <p style="font-size: 1.2em;">DUE TO, OR AS A CONSEQUENCE OF:</p> <p style="font-size: 1.2em;">(B) <u>anoxia</u></p> <p style="font-size: 1.2em;">DUE TO, OR AS A CONSEQUENCE OF:</p> <p style="font-size: 1.2em;">(C) <u>carcinoma of lung</u></p> <p style="font-size: 1.2em;">post thoracotomy/laparotomy</p> <p style="text-align: center;">II</p> <p style="text-align: center;">OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p> |  |  |   |  |  |
| <p>19A. DATE OF OPERATION</p> <p style="font-size: 1.1em;">11-5-69</p>  |  | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> <p style="font-size: 1.1em;">CANCER of LUNG</p>                          |   | <p>20A. AUTOPSY? (Yes or No)</p> <p style="font-size: 1.1em;">NO</p>                                 |  |
| <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p> <p style="font-size: 1.1em;">NO</p>   |  | <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p> <p style="font-size: 1.1em;">NO</p> |   |  |  |
| <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> <p style="font-size: 1.1em;">NO</p>   |  | <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> <p style="font-size: 1.1em;">NO</p>              |   |  |  |
| <p>21D. TIME OF INJURY (APPROX.)</p> <p style="font-size: 1.1em;">NO</p>  |  | <p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>             |   | <p>21F. HOW DID INJURY OCCUR?</p> <p style="font-size: 1.1em;">~</p>                                 |  |
| <p>22. I certify that (1) (this hospital) attended the deceased from <u>10-15</u> 19<u>69</u> to <u>11-6</u> 19<u>69</u> that (I) (we) last saw the deceased alive on <u>11-6 (7AM)</u> 19<u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>  |  |  |   |  |  |
| <p>23A. SIGNATURE</p> <p style="font-size: 1.2em;">Hugh Robinson MD</p>   |  |  | <p>23B. DATE SIGNED</p> <p style="font-size: 1.2em;">11-6-69</p>  |  | <p>23C. PHYSICIAN'S NAME (Type)</p> <p style="font-size: 1.1em;">Hugh Robinson, M.D.</p>   |
| <p>23D. ADDRESS</p> <p style="font-size: 1.1em;">The Johns Hopkins Hospital</p>   |  |  | <p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> <p style="font-size: 1.1em;">Burial</p>   |  |  |
| <p>24B. DATE</p> <p style="font-size: 1.1em;">11/10/69</p>  |  | <p>24C. NAME OF CEMETERY OR CREMATORY</p> <p style="font-size: 1.1em;">Woodlawn Cemetery</p>                                     |   | <p>24D. LOCATION (City, town, or county) (State)</p> <p style="font-size: 1.1em;">Baltimore, Md.</p> |  |
| <p>25A. NAME OF REGISTRAR</p> <p style="font-size: 1.1em;">Witzke, 1630 Edmondson Ave., Catonsville</p>   |  |  | <p>25B. FUNERAL DIRECTOR ADDRESS</p> <p style="font-size: 1.1em;">21228</p>   |  |  |



A-450

69 10965

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 10965

BIRTH NO.

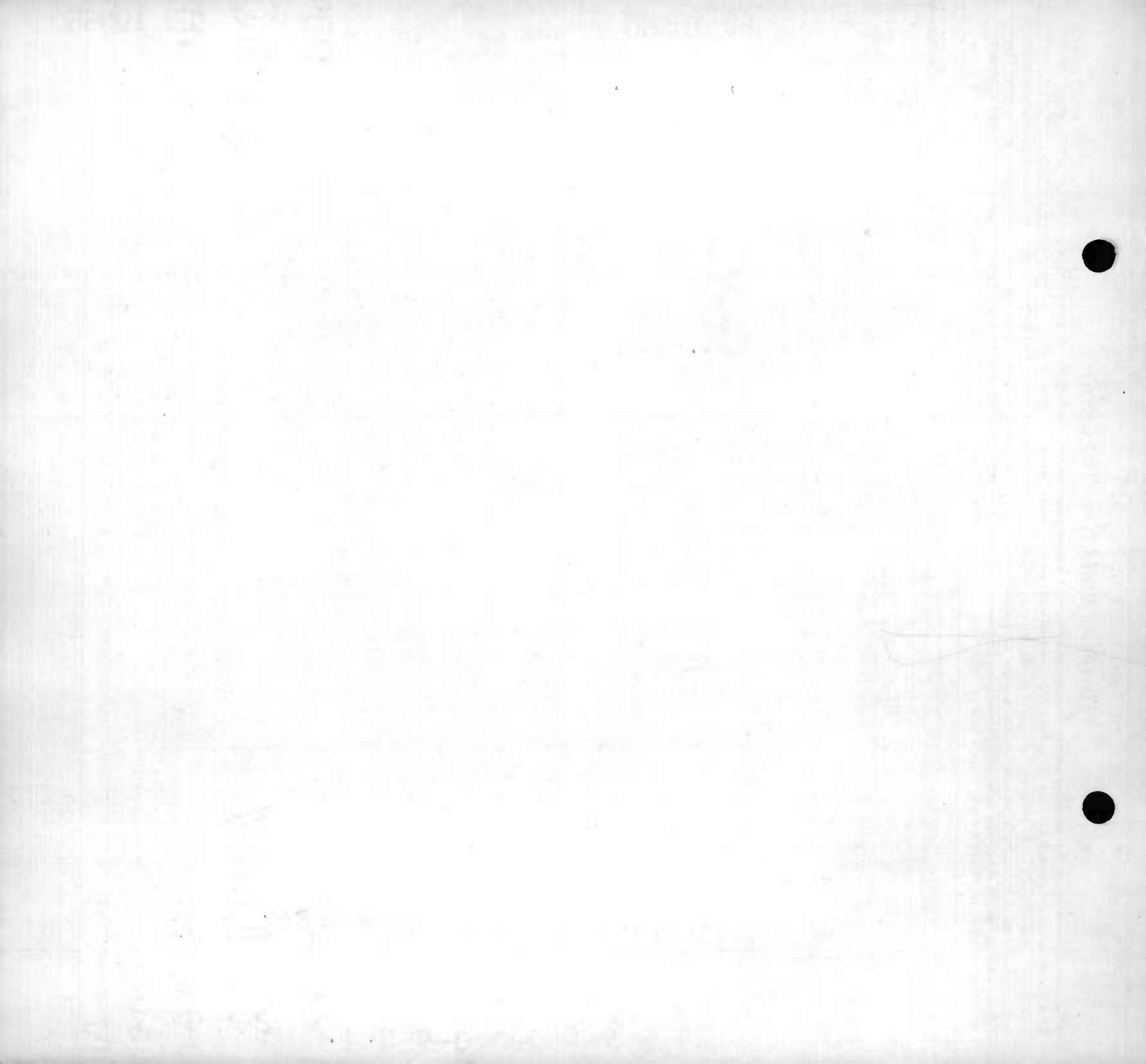
|   |  |   |  |
|---|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>VINCENT S. ALIMO</b>  |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> M.   |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>46 ST. AGNES HOSPITAL</b>  |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>November 5, 1969 11:30 A.M.</b>                              |  |
| 6. SEX<br>Male  |  | 7. RACE<br>White  |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | C. CITY OR TOWN<br>Reisterstown   |  |
| 9. DATE OF BIRTH<br>10/1/24   |  | 10. AGE (in years lost birthday) 45   |  |
| 11. BIRTHPLACE (State or foreign country)<br>Maryland   |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Truck Driver  |  | 15. MOTHER'S MAIDEN NAME<br>Josephine Alascio   |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>no   |  | 17. SOCIAL SECURITY NO.<br>217-18-1763  |  |
| 18. INFORMANT<br>Mrs. Vincent S. Alimo, 239 Homevale Rd.  |  | ADDRESS 21136   |  |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)<br><b>E 966X</b>   |  | CAUSE OF DEATH<br>Stab wounds of chest and neck   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:  |  |
|   |  | (B) DUE TO, OR AS A CONSEQUENCE OF:   |  |
|   |  | (C) DUE TO, OR AS A CONSEQUENCE OF:   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |  |   |  |
| 20A. DATE OF OPERATION  |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>Yard                  |  |
| 22D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX.) Nov. 5, 1969 11:10 A.M.  |  | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> |  |
| 22F. HOW DID INJURY OCCUR?<br>Stabbed during altercation  |  | 21. AUTOPSY? (Yes or No)<br>yes   |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br><b>Ronald N. Kornblum, M.D.</b>   |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |
|   |  | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |  | 24B. DATE<br>11/10/69   |  |
| 24C. NAME OF CEMETERY or CREMATORY<br>Woodlawn Cemetery   |  | 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Md.   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 7 1969   |  | 25B. NAME OF REGISTRAR<br>Robert E. Fisher, R.D.  |  |
| 25C. FUNERAL DIRECTOR<br>Witzke, 1630 Edmondson Ave., Catonsville   |  | ADDRESS<br>21228  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

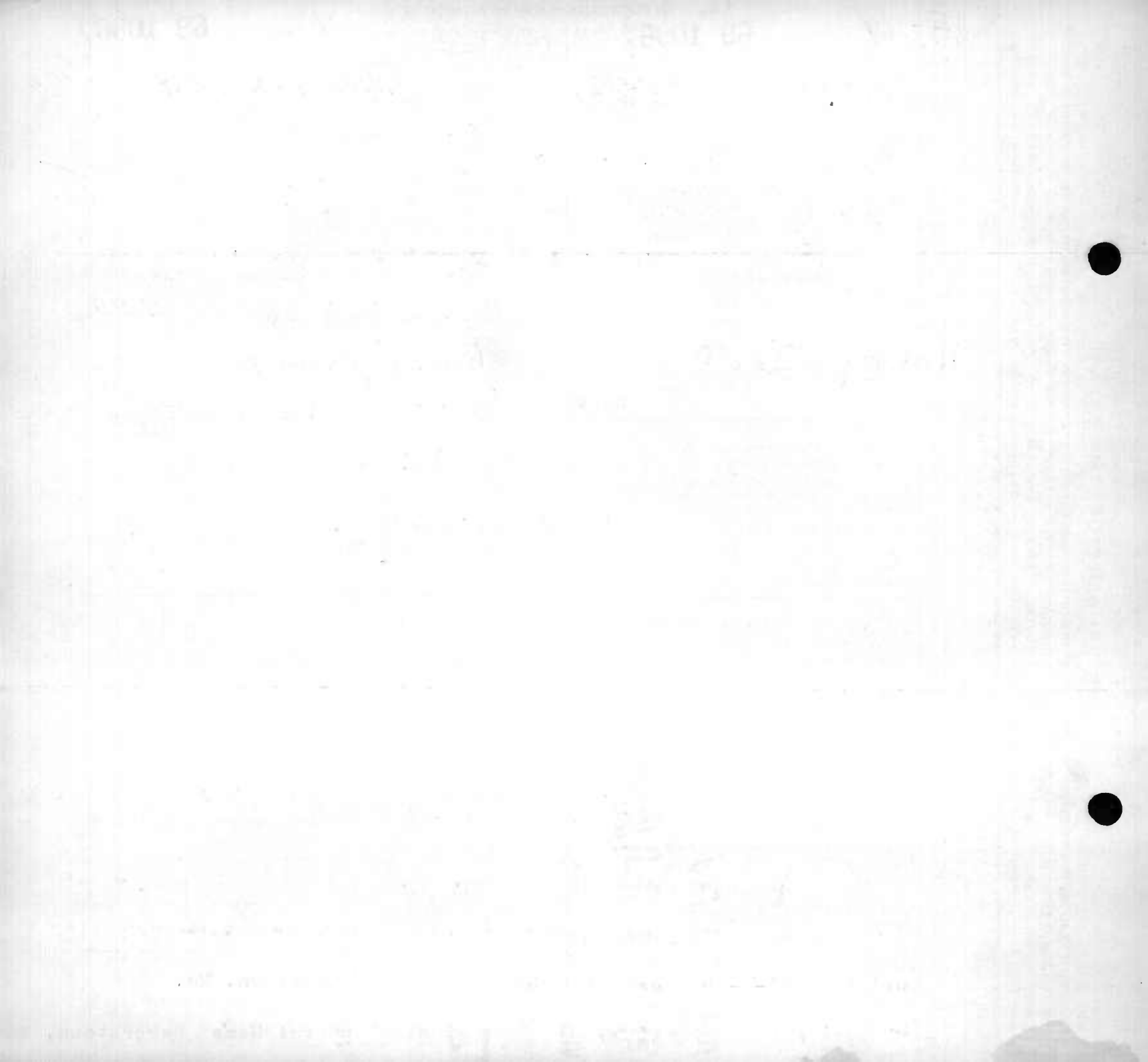
| BALTIMORE CITY HEALTH DEPARTMENT   |                             |   |   | REG. NO. <b>69 10966</b>   |
|--|-----------------------------|---|---|--|
| 1-512  |                             | 69 10966  |   | CERTIFICATE OF DEATH   |
| BIRTH NO.  |                             | 1. NAME OF DECEASED<br>(Type or Print) <b>THOMPSON, ELLA C.</b>   |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><b>LUTHERAN HOSPITAL OF MD.</b>  |                             | 2. DATE AND HOUR OF DEATH<br><b>11.5.69</b> <b>2 a.</b> M.  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>46</b>  |                             | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>1605</b>                          |   |  |
| C. CITY OR TOWN<br><b>BALTIMORE</b>  |                             | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |  |
| E. STREET AND NUMBER<br><b>2541 W. LANYALE ST.</b>   |                             |   |   |  |
| 5. SEX<br><b>FEMALE</b>  | 6. RACE<br><b>NEGRO</b>     | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>OCT. 4. 1925</b> | 9. AGE (In years lost birthday)<br><b>44</b>                             |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Claim Adjuster</b>   |                             | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Social Security</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>             |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>   |                             |   |   |  |
| 13. FATHER'S NAME<br><b>William I. Curry</b>   |                             | 14. MOTHER'S MAIDEN NAME<br><b>Pearl Heynie</b>   |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>  |                             | 16. SOCIAL SECURITY NO.<br><b>220126695</b>   |   | 17. INFORMANT<br><b>Melvin Thompson</b>                                  |
| 18. <b>533.91</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)<br><b>ACUTE HEART FAILURE</b>  |                             | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>Acute heart failure</b>   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10.26.69</b>          |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.   |                             | (B) <b>Post-op subtotal gastrectomy</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>bleeding peptic ulcer.</b>   |   | <b>11.5.69</b>   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>Advanced stage of fatty change in liver</b>   |                             |   |   |  |
| 19A. DATE OF OPERATION<br><b>10.26.69</b>  |                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Bleeding peptic ulcer.</b>   |   | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>            |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                             | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |   | 21F. HOW DID INJURY OCCUR?   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10.26.1969</b> to <b>11.5.1969</b> , that (I) (we) last saw the deceased alive on <b>10.4.1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                             |   |   |  |
| 23A. SIGNATURE<br><b>P. Gnanaswaran</b>  |                             | 23B. DATE SIGNED<br><b>11.5.69</b>  |   | 23C. PHYSICIAN'S NAME (Type)<br><b>P. GNANESWARAN</b>                    |
| 23D. ADDRESS<br><b>LUTHERAN HOSPITAL 730 ASHBURTON ST.</b>   |                             |   |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   | 24B. DATE<br><b>11-8-69</b> | 24C. NAME OF CEMETERY or CREMATORY<br><b>Arbutus Mem. Park</b>  | 24D. LOCATION (City, town, or county)   | (State)<br><b>Baltimore, Maryland</b>                                    |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 7 1969</b>   |                             | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor</b>   |   | 25C. FUNERAL DIRECTOR<br><b>Vernon Bailey</b>                            |
|  |                             |   |   | ADDRESS<br><b>1348 Calhoun Street</b>                                    |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |  |  |
|---|--|--|--|
| BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. <b>69 10967</b>   |  |
| <b>E-164</b>  |  | <b>69 10967</b>  |  |
| BIRTH NO.   |  | 1. NAME OF DECEASED<br>(Type or Print) <b>IRENE L. EVERLY</b>  |  |
| 2. DATE AND HOUR OF DEATH<br><b>NOVEMBER 26 5:45 AM</b>   |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>WASHINGTON</b>  |  | 5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>KEY CIRCLE HOSPICE</b><br><b>1214 EUTAW PLACE</b><br><b>BALTIMORE, MARYLAND</b> |  |
| C. CITY OR TOWN<br><b>HAGERSTOWN</b>  |  | D. INSIDE-CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| E. STREET AND NUMBER<br><b>941 C. LANVALE ST</b>  |  | 6. DATE OF BIRTH<br><b>1/27/27</b>   |  |
| 7. AGED (In years lost birthday) <b>78</b>  |  | 8. AGE (In years lost birthday) <b>78</b>  |  |
| 9. AGE (In years lost birthday) <b>78</b>   |  | 10. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Summerpoint VA.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   |  |
| 13. FATHER'S NAME<br><b>HARVEY FLOOD</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>MARY MOWEN</b>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces?<br>(Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>  |  | 16. SOCIAL SECURITY NO.<br><b>none</b>   |  |
| 17. INFORMANT<br><b>ANNA POMPELL</b>  |  | ADDRESS<br><b>941 C. LANVALE</b>   |  |
| 18. <b>41231</b>  |  | CAUSE OF DEATH   |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.)<br><b>A-S-H-O.</b>   |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  | (B) <b>Smoking</b><br>DUE TO, OR AS A CONSEQUENCE OF:  |  |
| (C) _____   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |  |  |
| 19A. DATE OF OPERATION<br><b>10-24-69</b>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20A. AUTOPSY? (Yes or No)<br><input type="checkbox"/>   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  |
| 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX.)   |  |
| 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10-24-69</b> to <b>NOV. 2 1969</b> , that (I) (we) last saw the deceased alive on <b>10-30-69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. |  |  |  |
| 23A. SIGNATURE<br><b>[Signature]</b>  |  | 23B. DATE SIGNED<br><b>11-4-69</b>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>T. J. J. J.</b>  |  | 23D. ADDRESS<br><b>110 5428 Sinclair LA</b>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>burial</b>   |  | 24B. DATE<br><b>11-5-69</b>  |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Rose Hill Cemetery</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>Hagerstown, Md.</b>  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 7 1969</b>  |  | 25B. NAME OF REGISTRAR<br><b>[Signature]</b>   |  |
| 25C. FUNERAL DIRECTOR<br><b>Minnich Funeral Home</b>  |  | ADDRESS<br><b>Hagerstown, Md</b>   |  |

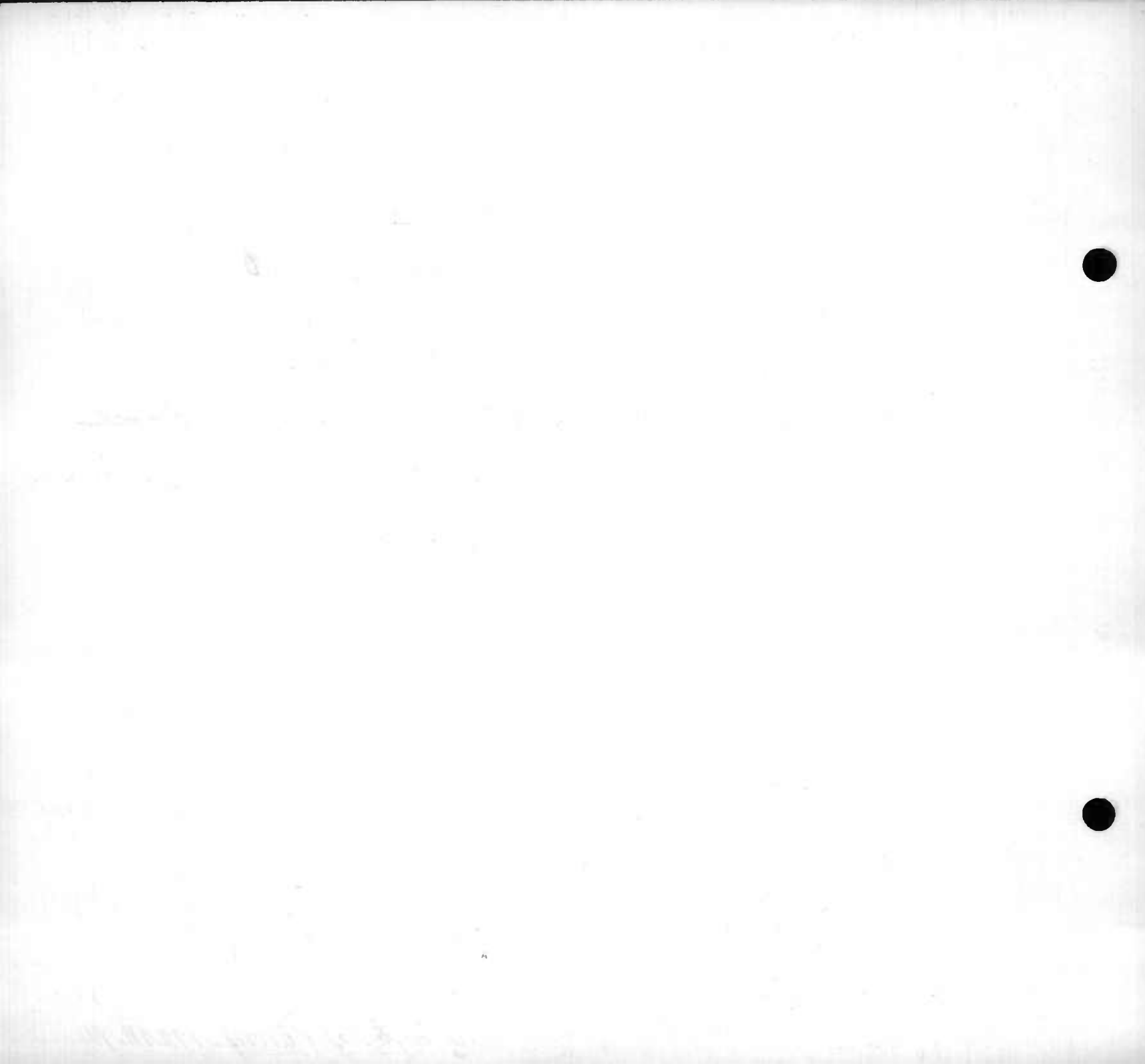




# FUNERAL DIRECTOR: IMPORTANT

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|   |                      |  |                                |  |   |
|---|----------------------|--|--------------------------------|--|---|
| A-536 69 10968  |                      | BALTIMORE CITY HEALTH DEPARTMENT   |                                | REG. NO. 69 10968  |   |
| BIRTH NO.   |                      | 1. NAME OF DECEASED<br>(Type or Print) Rosie Anderson (Rose)   |                                | 2. DATE AND HOUR OF DEATH<br>2 Nov 69 1915 P M.                          |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>Mercy Hospital   |                      | 4. USUAL RESIDENCE (Where deceased lived; If institution; residence before admission)<br>A. STATE B. COUNTY<br>Maryland Baltimore 2802<br>C. CITY OR TOWN<br>Baltimore<br>D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER<br>2911 Wendall Road |                                |  |   |
| 5. SEX<br>F   | 6. RACE<br>N         | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br>12-18-1928 | 9. AGE (In years, lost birthday)<br>40                                   | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Saleslady  |                      | 10B. KIND OF BUSINESS OR INDUSTRY  |                                | 11. BIRTHPLACE (State or foreign country)<br>Mississippi                 | 12. CITIZEN OF WHAT COUNTRY?<br>USA                         |
| 13. FATHER'S NAME<br>James Collins  |                      | 14. MOTHER'S MAIDEN NAME<br>Zella Jordan   |                                |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No  |                      | 16. SOCIAL SECURITY NO.<br>220-24-3191   |                                | 17. INFORMANT<br>Zella Harrell<br>ADDRESS<br>Same                        |   |
| 18. 43091<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>1. This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.<br>2. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                      | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>Subarachnoid Hemorrhage<br>(B) INTERCRANIAL ANEURYSM<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____   |                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 week                   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                      |  |                                |  |   |
| 19A. DATE OF OPERATION  |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                | 20A. AUTOPSY? (Yes or No)  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                                | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |                      | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                                | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from 31 Oct 69 to 2 Nov 1969 that (I) (we) last saw the deceased alive on 2 Nov 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                      |  |                                |  |   |
| 25A. SIGNATURE<br>Edward D. Layne M.D.  |                      |  |                                | 23B. DATE SIGNED<br>2 Nov 1969   |   |
| 23C. PHYSICIAN'S NAME (Type)<br>Edward D. Layne   |                      | 23D. ADDRESS<br>Mercy Hospital   |                                |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  | 24B. DATE<br>11/6/69 | 24C. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. Pl.   |                                | 24D. LOCATION (City, town, or county) (State)<br>Baltimore Md.           |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br>Nov 7 1969   |                      | 25B. NAME OF REGISTRAR<br>Robert E. Fisher, Jr.  |                                | 25C. FUNERAL DIRECTOR<br>Philip Phillips 172 M. Mount St.                |   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |  |  |   | REG. NO. <b>69 10969</b>  |  |
|--|--|--|---|---|--|
| <div style="display: flex; justify-content: space-between;"> <span><b>L-251</b></span> <span><b>69 10969</b></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>  |  |  |   |   |  |
| BIRTH NO.  |  | 1. NAME OF DECEASED<br>(Type or Print) <b>JOHN LEGAMBI</b>   |   | 2. DATE AND HOUR OF DEATH<br><b>11-3-69 2:30 A.M.</b>                                 |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>SOUTH BALTIMORE GENERAL Hospital</b>   |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD</b> B. COUNTY <b>ANNE ARUNDEL</b> |   |  |
| 5. SEX <b>M</b> 6. RACE <b>W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  | 8. DATE OF BIRTH<br><b>2-6-96</b>   |   | 9. AGE (In years last birthday)<br><b>73</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Custodian</b>  |  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Italy</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |
| 13. FATHER'S NAME<br><b>Pete Legambi</b>   |  |  | 14. MOTHER'S MAIDEN NAME<br><b>CAROLINE Vazzana</b>   |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>  |  | 16. SOCIAL SECURITY NO.<br><b>214-03-5443</b>  |   | 17. INFORMANT<br><b>Mrs. Mary Snyder Legambi</b>                                      |  |
| 18. <b>600X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)<br><b>Cardio - pulmonary arrest</b>  |  | CAUSE OF DEATH   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5</b>                              |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Concertine Heart Failure</b><br>(B) <b>Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Acute Myocardial Infarction</b><br>(C) <b>Prostatic Hypertrophy - Post-Op</b> |   |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |  |  |   |   |  |
| 19A. DATE OF OPERATION<br><b>10-30-69</b>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Urethral stricture</b>  |   | 20A. AUTOPSY? (Yes or No)<br><b>No</b>  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><b>No</b>   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>No</b>  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>No</b> |  |
| 21D. TIME OF INJURY (APPROX.)<br><b>No</b>   |  | 21E. INJURY OCCURRED<br>White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>   |   | 21F. HOW DID INJURY OCCUR?<br><b>No</b>   |  |
| 22. I certify that (X) (this hospital) attended the deceased from <b>10-20-69</b> 1969 to <b>11-3</b> 1969, that (X) (we) last saw the deceased alive on <b>11-3- (11 A.M.)</b> 1969 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. |  |  |   |   |  |
| 23A. SIGNATURE<br><b>Napoleon A. Abando</b>  |  |  |   | 23B. DATE SIGNED<br><b>11-3-69</b>  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>NAPOLION A. ABAUNDO</b>   |  |  |   | 23D. ADDRESS<br><b>SBG HT</b>   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>11-7-69</b>  |   | 24C. NAME OF CEMETERY or CREMATORY<br><b>Glen Haven</b>                               |  |
| 24D. LOCATION<br><b>Glen Burnie, Md.</b>   |  | 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 7 1969</b>   |   |   |  |
| 25B. NAME OF REGISTRAR<br><b>George J. Gonce</b>   |  | 25C. FUNERAL DIRECTOR<br><b>George J. Gonce 4001 Ritchie Hwy. Baltimore, Md. 21225</b>   |   |   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                  |   |                                 | REG. NO. <b>69 10970</b>   |
|---|------------------|---|---------------------------------|--|
| <b>M-633</b><br>BIRTH NO.   |                  | <b>69 10970</b>   |                                 | <b>CERTIFICATE OF DEATH</b>  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Mary Emma Meredith</b><br><b>MARY MEREDITH</b>  |                  | 2. DATE AND HOUR OF DEATH<br><b>11-5-69</b> <b>1:15</b> <b>A.M.</b>   |                                 |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>HARBOR VIEW N.C.C.</b><br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |                  | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>Balti.</b><br>C. CITY OR TOWN <b>Baltimore, 21231</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>217 Ballou Ct.</b> |                                 |  |
| 5. SEX <b>F</b>   | 6. RACE <b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <b>11-3-86</b> | 9. AGE (In years last birthday) <b>83</b>                                      |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>DIETITIAN</b>   |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Institutional Ind.</b>  |                                 | 11. BIRTHPLACE (State or foreign country)<br><b>New Jersey</b>                 |
| 13. FATHER'S NAME<br><b>William Cart</b>  |                  | 14. MOTHER'S MAIDEN NAME<br><b>MARY BURKESTRESSAR.</b>  |                                 |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                  | 16. SOCIAL SECURITY NO.<br><b>215-12-8987</b>   |                                 | 17. INFORMANT<br><b>Joseph Meredith</b>  |
| 18. <b>4-2-31</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>Coronary Arteriosclerosis</b>  |                  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Art. Sel. Cardiolax Disease</b>  |                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12 hr.</b>                  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Generalized Arteriosclerosis</b>   |                  | (B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>Peripheral Arteriosclerosis</b>   |                                 | <b>2 yrs.</b>  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>Osteoarthritis Spine &amp; Discogenic Disease</b>  |                  | (C) <b>2 yr.</b>  |                                 |  |
| 19A. DATE OF OPERATION<br><b>0</b>  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                 | 20A. AUTOPSY? (Yes or No)  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)       |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                                 | 21F. HOW DID INJURY OCCUR?   |
| 22. I certify that (I) ( <del>this</del> hospital) attended the deceased from <b>March</b> 19 <b>69</b> to <b>Nov. 5</b> 19 <b>69</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>11/4</b> 19 <b>69</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>We</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death. |                  |   |                                 |  |
| 23A. SIGNATURE<br><b>Kenneth Krulavitz MD</b>   |                  | 23B. DATE SIGNED<br><b>11/5/69</b>  |                                 |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Kenneth Krulavitz MD</b>   |                  | 23D. ADDRESS<br><b>115 W. Monument St. (21201)</b>  |                                 |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                  | 24B. DATE<br><b>11-8-69</b>   |                                 | 24C. NAME OF CEMETERY or CREMATORY<br><b>Glen Haven</b>                        |
| 24D. LOCATION (City, town, or county) (State)<br><b>Glen Burnie, Md.</b>  |                  |   |                                 |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 7 1969</b>  |                  | 25B. NAME OF REGISTRAR<br><b>George J. Gonce</b>  |                                 | 25C. FUNERAL DIRECTOR ADDRESS<br><b>4001 Ritchie Hgy. Baltimore, Md. 21223</b> |

Es

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                      |   |                                |
|---|----------------------|---|--------------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT  |                      | REG. NO. <b>69 10971</b>  |                                |
| BIRTH NO. <b>17-600</b>   |                      | 69 10971  |                                |
| 1. NAME OF DECEASED<br>(Type or Print) <b>MAHER, William Joseph Jr.</b>   |                      | 2. DATE AND HOUR OF DEATH<br><b>November 5, 1969 10:04 A M.</b>   |                                |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>(If not in hospital or institution, give street address or location)<br><b>23 Veterans Administration Hospital<br/>3900 Loch Raven Blvd.<br/>Baltimore, Maryland 21218</b>  |                      | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>Baltimore</b><br>C. CITY OR TOWN <b>Baltimore</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>1566 Ridgely St 603 Academy Road</b> |                                |
| 5. SEX <b>Male</b>  | 6. RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>   | 8. DATE OF BIRTH <b>4/9/27</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Carpenter</b>   |                      | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>unemployed</b>  |                                |
| 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md</b>   |                      | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                |
| 13. FATHER'S NAME<br><b>William J. Sr.</b>  |                      | 14. MOTHER'S MAIDEN NAME<br><b>Mildred Downey</b>   |                                |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NBS 5/23/45 - 7/3/46</b>   |                      | 16. SOCIAL SECURITY NO.<br><b>216-20-5052</b>   |                                |
| 17. INFORMANT<br><b>Mrs. Patsy Fendley, sister - 603 Academy Rd.</b>  |                      | ADDRESS<br><b>VA Hospital Records Baltimore, Md.</b>  |                                |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Pulmonary embolism suspected</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Carcinoma of lungs presumably</b> |                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>sudden</b><br><b>unknown</b>   |                                |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |                      |   |                                |
| 19A. DATE OF OPERATION<br><b>10/16/69</b>   |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Decompression &amp; Laminectomy</b>  |                                |
| 20A. AUTOPSY? (Yes or No)<br><b>NO</b>  |                      | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                                |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                      | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |                                |
| 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                      | 21F. HOW DID INJURY OCCUR?  |                                |
| 22. I certify that (I) (this hospital) attended the deceased from <b>October 14th 1969</b> to <b>November 5th 1969</b> , that (I) (we) last saw the deceased alive on <b>November 5th 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                      |   |                                |
| 23A. SIGNATURE<br><b>mygwell m.d.</b>   |                      | 23B. DATE SIGNED<br><b>11/5/69</b>  |                                |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Robert E. Taylor, M.D.</b>   |                      | 23D. ADDRESS<br><b>3900 Loch Raven Boulevard<br/>Baltimore, Maryland 21218</b>  |                                |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                      | 24B. DATE<br><b>11-10-69</b>  |                                |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Baltimore National</b>   |                      | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>   |                                |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 7 1969</b>  |                      | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>   |                                |
| 25C. FUNERAL DIRECTOR<br><b>George J. Gonce</b>   |                      | ADDRESS<br><b>4001 Ritchie Hgy. Baltimore, Md, 21225</b>  |                                |

11/11/69 - Correction form from funeral director.

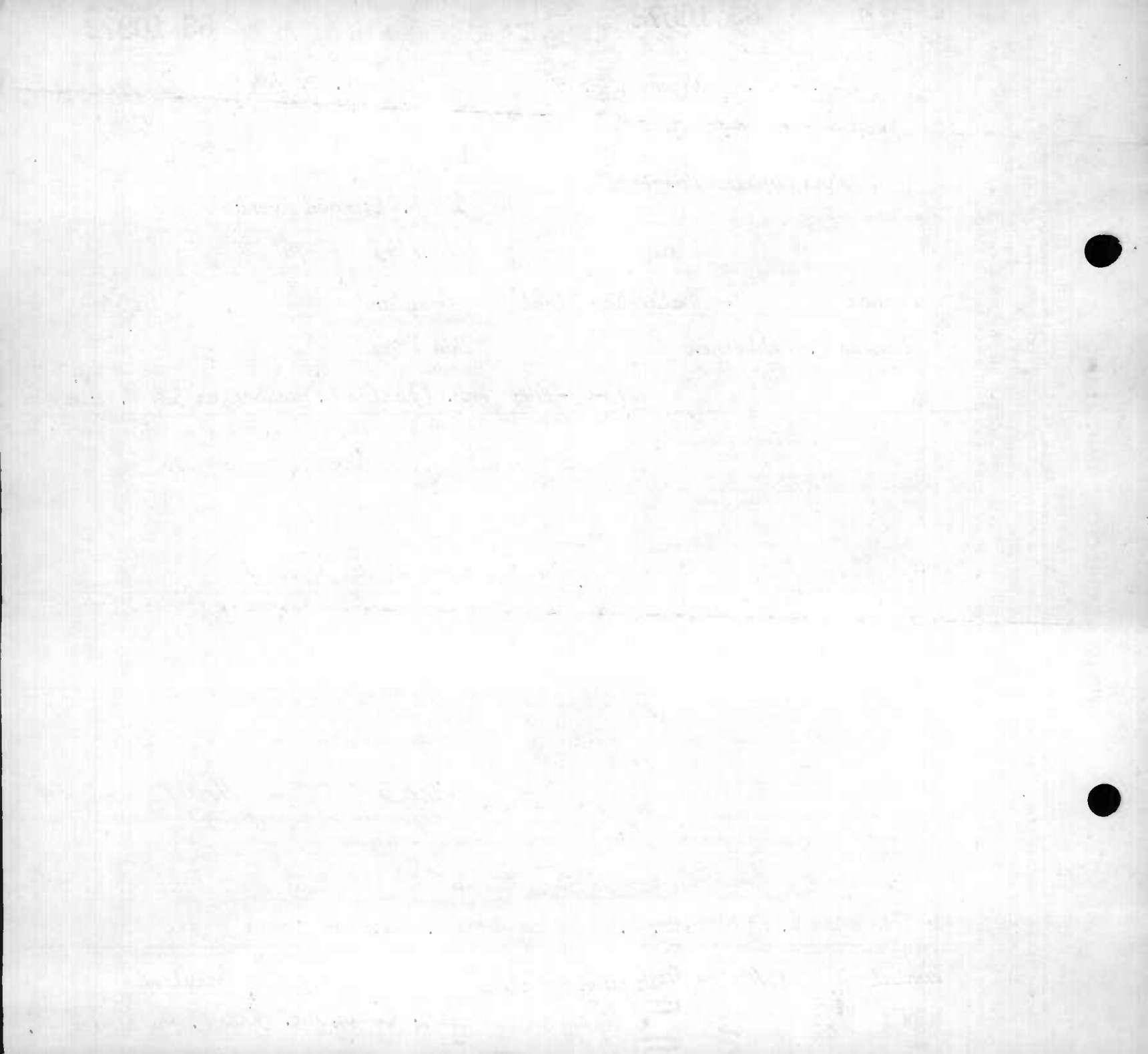
*Age.*



# FUNERAL DIRECTOR: IMPORTANT

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| BALTIMORE CITY HEALTH DEPARTMENT   |                     |   |                                      | REG. NO. <b>69 10972</b>   |   |
|--|---------------------|---|--------------------------------------|--|---|
| <div style="font-size: 2em; font-weight: bold;">8-162</div> <div style="font-size: 1.5em; font-weight: bold;">69 10972</div> <div style="font-size: 1.2em; font-weight: bold;">CERTIFICATE OF DEATH</div>  |                     |   |                                      |  |   |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Charles C. Rehberger, Jr.</i>  |                     |   |                                      | 2. DATE AND HOUR OF DEATH<br><i>Nov. 2, '69</i>  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                     |   |                                      | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY <i>701</i>   |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>33 Johns Hopkins Hospital</i>   |                     |   |                                      | C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |
|  |                     |   |                                      | E. STREET AND NUMBER<br><i>524 N. Linwood Avenue</i>   |   |
| 5. SEX<br><i>M</i>   | 6. RACE<br><i>W</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>10/25/'93</i> | 9. AGE (In years last birthday)<br><i>76</i>   | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Burner</i>   |                     | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Bethlehem Steel</i>   |                                      | 11. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>   |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |                     |   |                                      |  |   |
| 13. FATHER'S NAME<br><i>Charles C. Rehberger</i>   |                     |   |                                      | 14. MOTHER'S MAIDEN NAME<br><i>Ida Fray</i>  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>No</i>  |                     | 16. SOCIAL SECURITY NO.<br><i>213-09-2449</i>   |                                      | 17. INFORMANT<br><i>Mrs. Charles C. Rehberger</i>  |   |
|  |                     |   |                                      | ADDRESS <i>Av. 524 N. Linwood</i>  |   |
| 18. <i>412.41-162.1</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br><i>II</i><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |                     |   |                                      | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br><i>Cardiac Decompensation</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <i>ASCVD</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <i>Carcinoma of Lung</i><br><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |
| 19A. DATE OF OPERATION<br><i>0</i>   |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                      | 20A. AUTOPSY? (Yes or No)  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                      | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                                      | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1963</i> to <i>Nov 2</i> 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>Oct 27</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                     |   |                                      |  |   |
| 23A. SIGNATURE<br><i>Charles C. MacMinn M.D.</i>   |                     |   |                                      | 23B. DATE SIGNED<br><i>November 5, 1969</i>  |   |
| 23C. PHYSICIAN'S NAME (Type)<br><i>Charles C. MacMinn, M. D.</i>   |                     |   |                                      | 23D. ADDRESS<br><i>2900 E. Baltimore Street</i>  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |                     | 24B. DATE<br><i>11/6/'69</i>  |                                      | 24C. NAME OF CEMETERY or CREMATORY<br><i>Oak Lawn Cemetery</i>   |   |
|  |                     |   |                                      | 24D. LOCATION (City, town, or county) (State)<br><i>Baltimore, Maryland</i>  |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>NOV 7 1969</i>   |                     | 25B. NAME OF REGISTRAR<br><i>Robert E. Taylor, R.R.</i>   |                                      | 25C. FUNERAL DIRECTOR<br><i>John A. Moran, Inc.</i>  |   |
|  |                     |   |                                      | ADDRESS<br><i>3000 E. Baltimore St.</i>  |   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                         |   |  |   |  |   |  |
|--|-------------------------|---|--|---|--|---|--|
| W-300  |                         | 69 10973  |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. 69 10973   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Wood, Louis Allen</i>  |                         |   |  | 2. DATE AND HOUR OF DEATH<br><i>11-4-69 11:30 A.M.</i>  |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><i>South Baltimore General 43</i>   |                         |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>MD.</i> B. COUNTY <i>Bn</i><br>C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <i>1809 Fredrick Ave.</i> |  |   |  |
| 5. SEX<br><i>Male</i>  | 6. RACE<br><i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><i>Apr. 23, 1905</i>  | 9. AGE (In years last birthday)<br><i>64</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Cook</i>   |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Spring Grove St. Hosp</i>   |  | 11. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                  |  |
| 13. FATHER'S NAME<br><i>Elliott Wood</i>   |                         |   |  | 14. MOTHER'S MAIDEN NAME<br><i>Unknown</i>  |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>Yes <input checked="" type="checkbox"/> July 1926-1930   |                         | 16. SOCIAL SECURITY NO.<br><i>219-12-8364</i>   |  | 17. INFORMANT<br><i>Elizabeth Wood</i>  |  | ADDRESS<br><i>21223 1809 Frederick Ave.</i>                                 |  |
| 18. <i>3-74-91</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) sloting the UNDERLYING CONDITION last.                 |                         |   |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><i>Septic Shock</i><br><i>cholelithiasis</i><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:  |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                         |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |
| 19A. DATE OF OPERATION<br><i>0</i>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?        |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |  |   |  |
| 22. I certify that <del>(at)</del> (this hospital) attended the deceased from <i>Oct 25 at 6 PM 19 69</i> to <i>Nov 4 11:30 AM 19 69</i> , that (I) (we) last saw the deceased alive on <i>Nov 4</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |   |  |   |  |   |  |
| 23A. SIGNATURE<br><i>Daniel M. Howell MD.</i>  |                         |   |  | 23B. DATE SIGNED<br><i>11-4-69</i>  |  | 23C. PHYSICIAN'S NAME (Type)<br><i>DANIEL M. HOWELL MD.</i>                 |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |                         | 24B. DATE<br><i>11/7/69</i>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><i>Balto. National Cemetery</i>   |  | 24D. LOCATION (City, town, or county) (State)<br><i>Baltimore, Maryland</i> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>NOV 7 1969</i>   |                         | 25B. NAME OF REGISTRAR<br><i>Reese</i>  |  | 25C. FUNERAL DIRECTOR<br><i>Walters Funeral Home</i>  |  | ADDRESS<br><i>Pratt &amp; Stricker Sts.</i>                                 |  |

Mr. J. H. ...

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                         |   |                                      |   |  |
|--|-------------------------|---|--------------------------------------|---|--|
| M-536  |                         | BALTIMORE CITY HEALTH DEPARTMENT  |                                      | REG. NO. 69 10974   |  |
| BIRTH NO. 69 10974   |                         | CERTIFICATE OF DEATH  |                                      |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Montier, Walter</u>  |                         | 2. DATE AND HOUR OF DEATH<br><u>11/4/69</u> <u>1:50 PM</u> M.   |                                      |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                         | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <u>Maryland</u> B. COUNTY <u>1502</u>                     |                                      |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>Lutheran Hospital</u><br><u>46</u>  |                         | C. CITY OR TOWN<br><u>Baltimore</u>   |                                      | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| E. STREET AND NUMBER<br><u>1710 McKean Avenue</u>  |                         |   |                                      |   |  |
| 5. SEX<br><u>MALE</u>  | 6. RACE<br><u>NEGRO</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>4-16-1891</u> | 9. AGE (In years lost birthday)<br><u>78</u>  | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired</u>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY   |                                      | 11. BIRTHPLACE (State or foreign country)<br><u>Norfolk, Va.</u>                              |  |
| 12. CITIZEN OF WHAT COUNTRY?   |                         | 13. FATHER'S NAME<br><u>unknown</u>   |                                      |   |  |
| 14. MOTHER'S MAIDEN NAME<br><u>unknown</u>   |                         | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>no</u>                                       |                                      |   |  |
| 16. SOCIAL SECURITY NO.<br><u>826-02-1969</u>  |                         | 17. INFORMANT<br><u>Rose Mitchell - 1710 McKean Ave</u>   |                                      |   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease or complication which caused death.)<br><u>ASCVD</u><br><u>CHD? Degeneration?</u><br><u>He died as soon as he reached floor</u>  |                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                                      |   |  |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, give rise to the above cause (A) stating UNDERLYING CONDITION last.   |                         |   |                                      |   |  |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                         |   |                                      |   |  |
| 21A. DATE OF OPERATION<br><u>0</u>   |                         | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                      | 21C. AUTOPSY? (Yes or No)   |  |
| 21D. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                         | 21E. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                      | 21F. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |  |
| 21G. TIME OF INJURY (APPROX.)  |                         | 21H. INJURY OCCURRED  |                                      | 21I. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (X) (this hospital) attended the deceased from <u>11. 4.</u> 19 <u>69</u> , that (X) (I) lost saw the deceased alive on <u>11. 4.</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. |                         |   |                                      |   |  |
| 23A. SIGNATURE<br><u>Zaher Ahmad Khan</u>  |                         | 23B. DATE SIGNED  |                                      | 23C. PHYSICIAN'S NAME (Type)<br><u>ZAHNER AHMAD KHAN</u>                                      |  |
| 23D. ADDRESS<br><u>90 Lutheran Hospital</u>  |                         | 23E. ATTENDING PHYSICIAN<br>Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |                                      |   |  |
| 24A. BURIAL CREMATION REMOVAL (Specify)<br><u>Burial</u>   |                         | 24B. DATE<br><u>11/8/69</u>   |                                      | 24C. NAME OF CEMETERY OR CREMATORY<br><u>Mt. Auburn Cem</u>                                   |  |
| 24D. LOCATION (City, town, or county) (State)<br><u>Balto Maryland</u>   |                         | 24E. FUNERAL DIRECTOR<br><u>Earl Simon</u>  |                                      |   |  |
| 24F. ADDRESS<br><u>1827 W. North Ave</u>   |                         |   |                                      |   |  |

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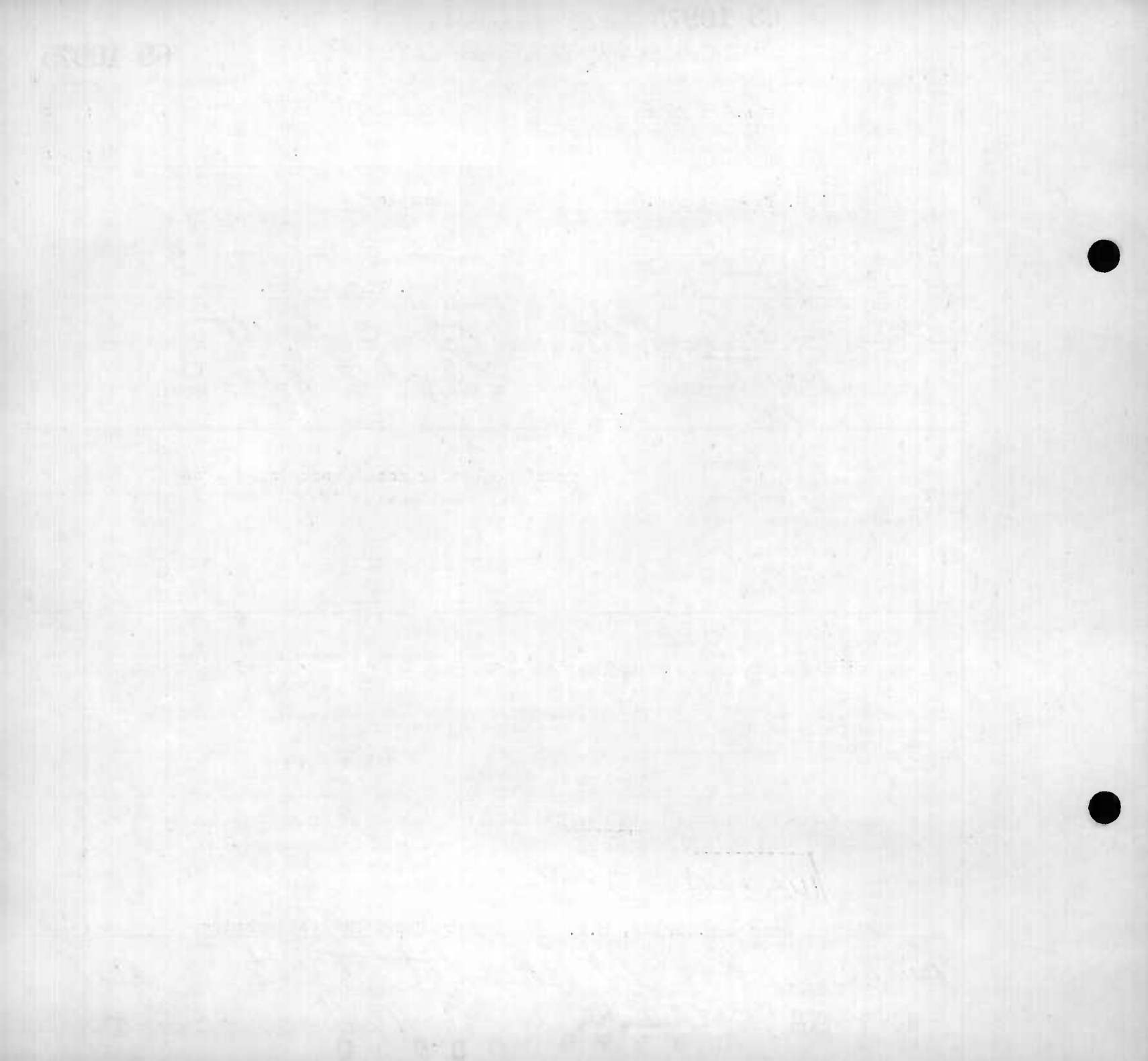
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5-530 69 10975 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 69 10975

|   |                           |  |  |  |  |
|---|---------------------------|--|--|--|--|
| BIRTH NO.   |                           | 1. NAME OF DECEASED<br>(Type or Print)<br><b>Charles Smith</b>   |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> 11 4 69 10:18 a.m. |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>714 N. Fremont Ave.</b>   |                           | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br>11 4 69 10:18 a.m.   |  | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>1601</b>    |  |
| 6. SEX<br><b>male</b>   | 7. RACE<br><b>colored</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | C. CITY OR TOWN<br><b>Baltimore</b>  |  |
| 9. DATE OF BIRTH<br><b>8-29-1893</b>  |                           | 10. AGE (In years lost birthday)<br><b>76</b>  |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>  |                           | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | E. STREET AND NUMBER<br><b>714 N. Fremont Ave.</b>   |  |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>  |                           | 14B. KIND OF BUSINESS OR INDUSTRY  |  | 13. FATHER'S NAME<br><b>John E. Smith</b>  |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service)<br><b>No</b>   |                           | 17. SOCIAL SECURITY NO.<br><b>214-12-4109</b>  |  | 15. MOTHER'S MAIDEN NAME<br><b>Elizabeth Green</b>   |  |
| 18. INFORMANT   |                           | ADDRESS  |  |  |  |
| 19. CAUSE OF DEATH<br><b>412.4 I</b>  |                           | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Arteriosclerotic cardiovascular disease</b><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF: |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>ANTECEDENT CAUSES</b>   |                           | (B) DUE TO, OR AS A CONSEQUENCE OF:  |  |  |  |
| (C)   |                           |  |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                           |  |  |  |  |
| 20A. DATE OF OPERATION  |                           | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 21. AUTOPSY? (Yes or No)<br><b>no</b>  |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                           | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                           | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 22F. HOW DID INJURY OCCUR?   |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                           |  |  |  |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br><b>Werner U. Spitz, M.D.</b>  |                           | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>Deputy Chief Medical Examiner   |  | DATE SIGNED<br><b>11/4/69</b>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                           | 24B. DATE<br><b>11-8-69</b>  |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>mt Auburn Cmt</b>   |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Balto Md</b>  |                           | 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 7 1969</b>   |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Jaber, M.D.</b>   |  |
| 25C. FUNERAL DIRECTOR<br><b>Choy Wilson</b>   |                           | ADDRESS<br><b>1000 Cranberry Ave</b>   |  |  |  |



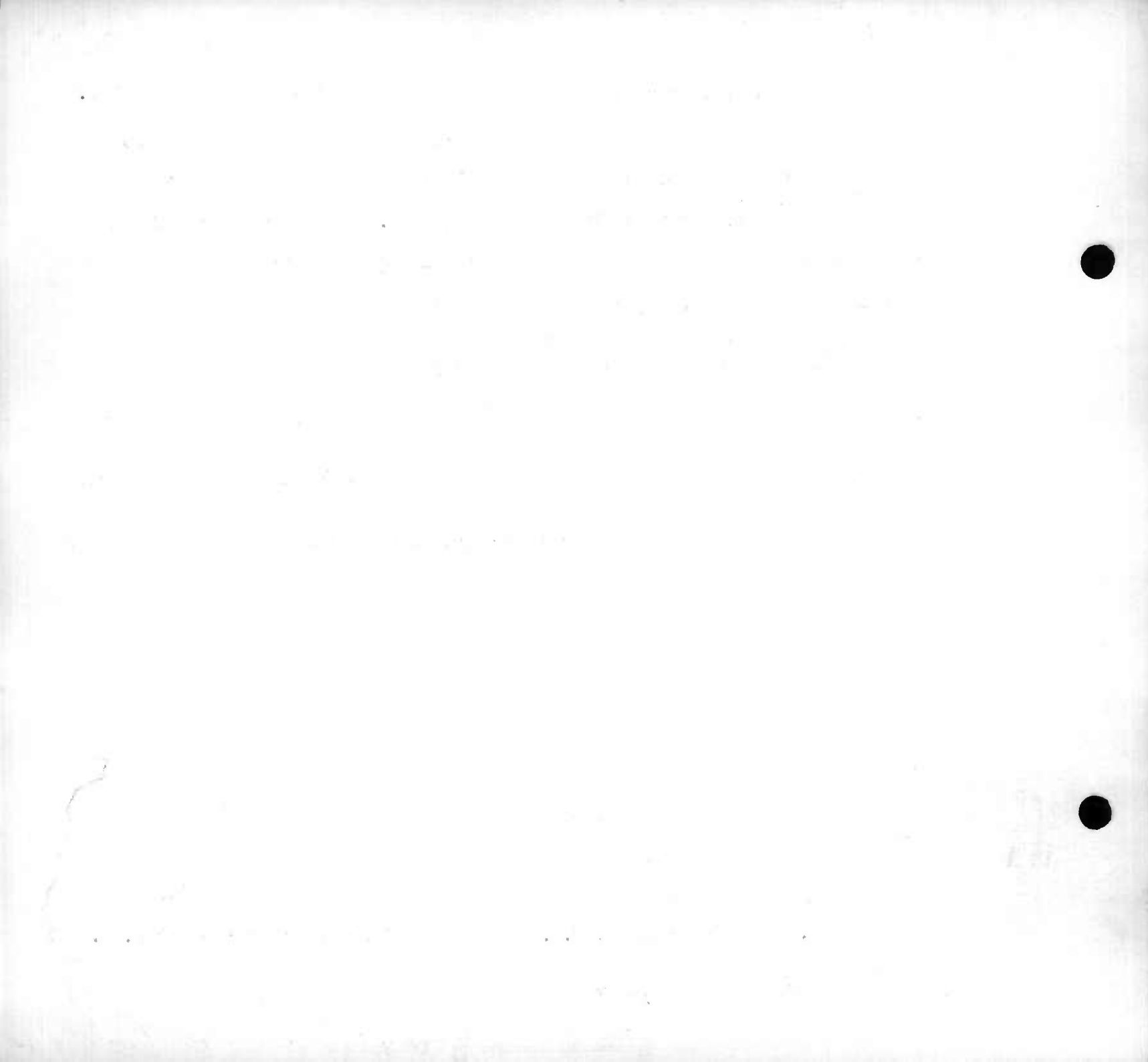




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| G-612   |  | BALTIMORE CITY HEALTH DEPARTMENT |   | REG. NO. 69 10976 |   |
|---|--|----------------------------------|---|-------------------|---|
| BIRTH NO. 69 10976  |  | CERTIFICATE OF DEATH             |   | 11/5/69 9 P. M.   |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Randall Gravesandee</b>   |  |                                  | 2. DATE AND HOUR OF DEATH   |                   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  |                                  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>1510</b> |                   |   |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>39 PROVIDENT HOSPITAL, COMPLEX<br/>1514 DIVISION STREET<br/>BALTIMORE, MARYLAND 21217</b>   |  |                                  | C. CITY OR TOWN<br><b>Baltimore</b>   |                   | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX <b>Male</b> 6. RACE <b>Indian</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |                                  | 8. DATE OF BIRTH<br><b>3-17-1895</b>  |                   | 9. AGE (in years last birthday) <b>74</b>   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>retired</b>   |  |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>retired</b>   |                   | 11. BIRTHPLACE (State or foreign country)<br><b>India</b>                                     |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>India</b>  |  |                                  | 13. FATHER'S NAME<br><b>Randolph Gravesandee</b>  |                   |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Modalee Donkree</b>  |  |                                  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                   |                   |   |
| 16. SOCIAL SECURITY NO.   |  |                                  | 17. INFORMANT<br><b>Mrs. Carrie Gravesandee</b>   |                   |   |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>4109 I</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |  |                                  | (A) IMMEDIATE CAUSE <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF:   |                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 months</b>                               |
|   |  |                                  | (B) <b>Arteriosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF:  |                   | <b>1 years</b>  |
|   |  |                                  | (C) _____   |                   |   |
| 19A. DATE OF OPERATION  |  |                                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                   | 20A. AUTOPSY? (Yes or No)   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |  |                                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |  |                                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                  |                   | 21F. HOW DID INJURY OCCUR?  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>11/5/68</b> 19__ to <b>11/5/69</b> 19__ that (I) (we) last saw the deceased alive on <b>11/5/69</b> 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.  |  |                                  |   |                   |   |
| 23A. SIGNATURE<br><b>G. Franklin Phillips, M.D.</b>   |  |                                  | 23B. DATE SIGNED<br><b>11/6/69</b>  |                   | 23C. PHYSICIAN'S NAME (Type)<br><b>G. Franklin Phillips, M.D.</b>                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |                                  | 24B. DATE<br><b>11-7-69</b>   |                   | 24C. NAME of CEMETERY or CREMATORY<br><b>Arbutus Memorial Park</b>                            |
| 24D. LOCATION<br><b>Arbutus Md.</b>   |  |                                  | 25A. DATE RECD BY HEALTH DEPT.<br><b>NOV 7 1969</b>   |                   |   |
| 25B. NAME of REGISTRAR<br><b>Robert E. Vahey, M.D.</b>  |  |                                  | 25C. FUNERAL DIRECTOR<br><b>Henry O. Wilson</b>   |                   |   |
| 25D. ADDRESS<br><b>1000 Broadway Ave.</b>   |  |                                  |   |                   |   |



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 10977

BIRTH NO.

|   |  |  |  |
|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>General Barfield</b>   |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> M.  |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>00 222 N. Greene St. (DOA)</b>   |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>11 2 69 2:20 P. M.</b>  |  |
| 6. SEX<br><b>Male</b>   |  | 7. RACE<br><b>Negro</b>  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | C. CITY OR TOWN<br><b>Baltimore</b>  |  |
| 9. DATE OF BIRTH<br>10. AGE (In years lost birthday)<br><b>63</b>   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>WILMINGTON N.C.</b>   |  | E. STREET AND NUMBER<br><b>222 N. Greene St.</b>   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 13. FATHER'S NAME<br><b>GENERAL BARFIELD</b>   |  |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, or as if retired)<br><b>Retired</b>   |  | 15. MOTHER'S MAIDEN NAME<br><b>ROSETTA BLACK</b>   |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |  | 17. SOCIAL SECURITY NO.  |  |
| 18. INFORMANT<br><b>Esther Lunsdown 4014 Carlish St.</b>  |  | ADDRESS  |  |
| 19. <b>412.4</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Arteriosclerotic cardiovascular disease</b>  |  | CAUSE OF DEATH<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 20. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) DUE TO, OR AS A CONSEQUENCE OF:                             |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |  |  |
| 20A. DATE OF OPERATION<br><b>2</b>  |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  | 22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)  |  |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 22F. HOW DID INJURY OCCUR?   |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |
| ACTUAL SIGNATURE<br><b>Russell S. Fisher, M.D.</b>  |  | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |  |
| EXAMINER'S NAME (Type)  |  | DATE SIGNED<br><b>11-3-69</b>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 24B. DATE<br><b>11-6-69</b>  |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>ARUNDEL Co. Md</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>ARUNDEL Co. Md</b>   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 7 1969</b>  |  | 25B. NAME OF REGISTRAR<br><b>Chas E. Fisher</b>  |  |
| 25C. FUNERAL DIRECTOR<br><b>Chas E. Fisher</b>  |  | ADDRESS<br><b>4000 Brantley Rd</b>   |  |



BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. **69 10978**

BIRTH NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| <b>1. NAME OF DECEASED</b><br>(Type or Print)<br><p align="center"><b>Norman J. Sapp</b></p>  |  |  |  | <b>2. DATE OF DEATH</b><br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month Day Year Hour<br><p align="center">11 3 69 1:05 p M.</p>   |  |  |  |
| <b>4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><p align="center"><b>2700 E. Fairmount Ave.</b></p>   |  |  |  | <b>3. DATE PRONOUNCED DEAD</b><br>Month Day Year Hour<br><p align="center">11 3 69 1:05 p M.</p>  |  |  |  |
| <b>5. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>602</b>   |  |  |  | <b>6. SEX</b> <b>male</b> <b>7. RACE</b> <b>white</b> <b>8. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>   |  |  |  |
| <b>9. DATE OF BIRTH</b><br><p align="center"><b>10/21/'18</b></p>   |  |  |  | <b>10. AGE</b> (In years last birthday) <b>51</b> <b>11. BIRTHPLACE</b> (State or foreign country)<br><p align="center"><b>Baltimore, Maryland</b></p>  |  |  |  |
| <b>12. CITIZEN OF WHAT COUNTRY?</b><br><p align="center"><b>USA</b></p>   |  |  |  | <b>13. FATHER'S NAME</b><br><p align="center"><b>John Frederick Sapp</b></p>  |  |  |  |
| <b>14A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><p align="center"><b>Mechanic</b></p>   |  |  |  | <b>14B. KIND OF BUSINESS OR INDUSTRY</b><br><p align="center"><b>Mrs. May Hieggby 109 N. Lakewood Ave</b></p>   |  |  |  |
| <b>16. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no or unknown) (If yes, give war or dates of service)<br><p align="center"><b>No</b></p>  |  |  |  | <b>17. SOCIAL SECURITY NO.</b><br><p align="center"><b>217-07-6664</b></p>  |  |  |  |
| <b>19. CAUSE OF DEATH</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><p align="center"><b>Arteriosclerotic cardiovascular disease</b></p>   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><p align="center"><b>412.7</b></p>  |  |  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><p align="center"><b>II</b></p>   |  |  |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><p align="center"><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A):</b></p>   |  |  |  |
| <b>20A. DATE OF OPERATION</b><br><p align="center"><b>0</b></p>   |  |  |  | <b>20B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b><br><p align="center"><b>21. AUTOPSY? (Yes or No)</b><br/> <p align="center"><b>no</b></p> </p>  |  |  |  |
| <b>22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.</b><br>(Type or Print)<br><p align="center"><b>22B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)<br/> <p align="center"><b>22C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)<br/> <p align="center"><b>22D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)<br/> <p align="center"><b>22E. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/><br/> <p align="center"><b>22F. HOW DID INJURY OCCUR?</b></p> </p> </p> </p></p> |  |  |  | I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Werner U. Spitz</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>Deputy Chief Medical Examiner <input type="checkbox"/> DATE SIGNED <b>11/4/69</b> |  |  |  |
| <b>24A. BURIAL CREMATION, REMOVAL</b> (Specify)<br><p align="center"><b>Burial</b></p>  |  |  |  | <b>24B. DATE</b><br><p align="center"><b>11/7/'69</b></p>   |  |  |  |
| <b>24C. NAME OF CEMETERY or CREMATORY</b><br><p align="center"><b>Oak Lawn Cemetery</b></p>   |  |  |  | <b>24D. LOCATION</b> (City, town, or county) (State)<br><p align="center"><b>Baltimore, Maryland</b></p>  |  |  |  |
| <b>25A. DATE REC'D BY HEALTH DEPT.</b><br><p align="center"><b>NOV 7 1969</b></p>   |  |  |  | <b>25B. NAME OF REGISTRAR</b><br><p align="center"><b>Robert E. Farley, M.D.</b></p>  |  |  |  |
| <b>25C. FUNERAL DIRECTOR ADDRESS</b><br><p align="center"><b>John A. Moran, Inc. 3000 E. Baltimore St.</b></p>  |  |  |  |   |  |  |  |

1001 50

WALLACE V. BROWN

WALLACE V. BROWN

WALLACE V. BROWN



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 10979

BIRTH NO.

|  |  |                             |  |  |  |   |  |
|--|--|-----------------------------|--|--|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>Raymond B. Brehm</b>  |  |                             |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month Day Year Hour<br><b>11 3 69 45:04 p.m.</b> |  |   |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>31 City Hospitals</b>   |  |                             |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>11 3 69 5:04 p.m.</b>   |  |   |  |
| 6. SEX<br><b>male</b>  |  |                             |  | 7. RACE<br><b>white</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. DATE OF BIRTH<br><b>Nov. 2, '56</b>   |  |                             |  | 10. AGE (In years lost birthday)<br><b>13 12</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b>   |  |
| 12. CITIZEN OF<br><b>USA</b>   |  |                             |  | 13. FATHER'S NAME<br><b>Joseph Brehm</b>   |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>School</b>   |  |
| 15. MOTHER'S MAIDEN NAME<br><b>Helen Mangus</b>  |  |                             |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>                                |  | 17. SOCIAL SECURITY NO.   |  |
| 18. INFORMANT<br><b>Mr. John C. Mangus</b>   |  |                             |  | 19. ADDRESS<br><b>109 N. Clinton St.</b>   |  |   |  |
| 20. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Exsanguination</b><br><b>Multiple cuts</b>  |  |                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |                             |  |  |  |   |  |
| 20A. DATE OF OPERATION<br><b>2</b>   |  |                             |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.<br><input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING   |  |                             |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>home</b>  |  |   |  |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>backyard - 109 N. Clinton St.</b>   |  |                             |  | 22D. TIME OF INJURY (APPROX.)<br><b>11 3 69 4:30 p.</b>  |  |   |  |
| 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |                             |  | 22F. HOW DID INJURY OCCUR?<br><b>bottle containing dry ice exploded causing multiple cuts</b>  |  |   |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> M.D.<br>EXAMINER'S NAME (Type)<br>Deputy Chief Medical Examiner<br>DATE SIGNED <b>11/4/69</b> |  |                             |  |  |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>11/7/69</b> |  | 24C. NAME of CEMETERY or CREMATORY<br><b>Oak Lawn Cemetery</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 7 1969</b>   |  |                             |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Spitz, M.D.</b>   |  | 25C. FUNERAL DIRECTOR ADDRESS<br><b>John A. Moran, Inc. 3000 E. Baltimore St</b>  |  |

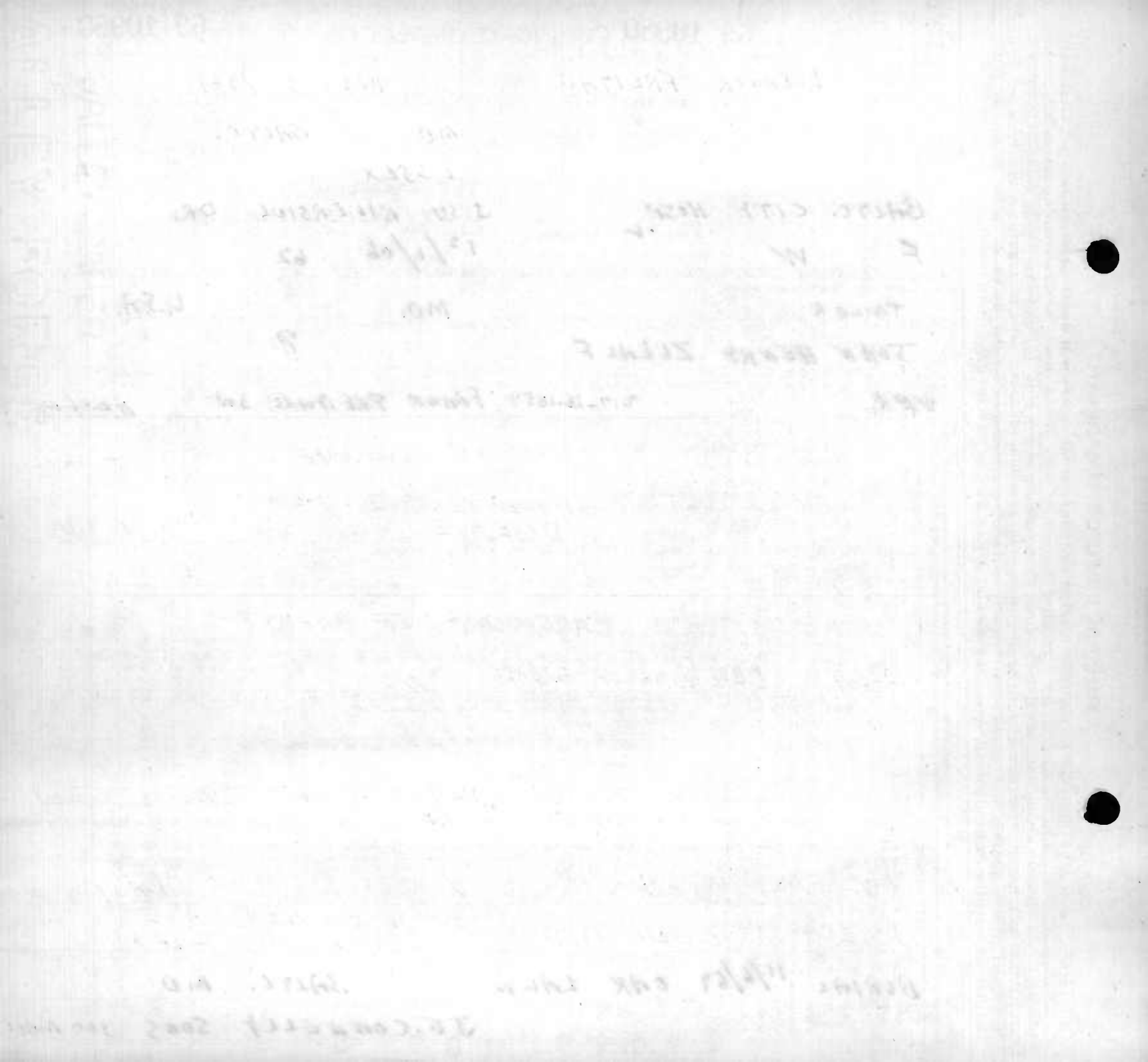




**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

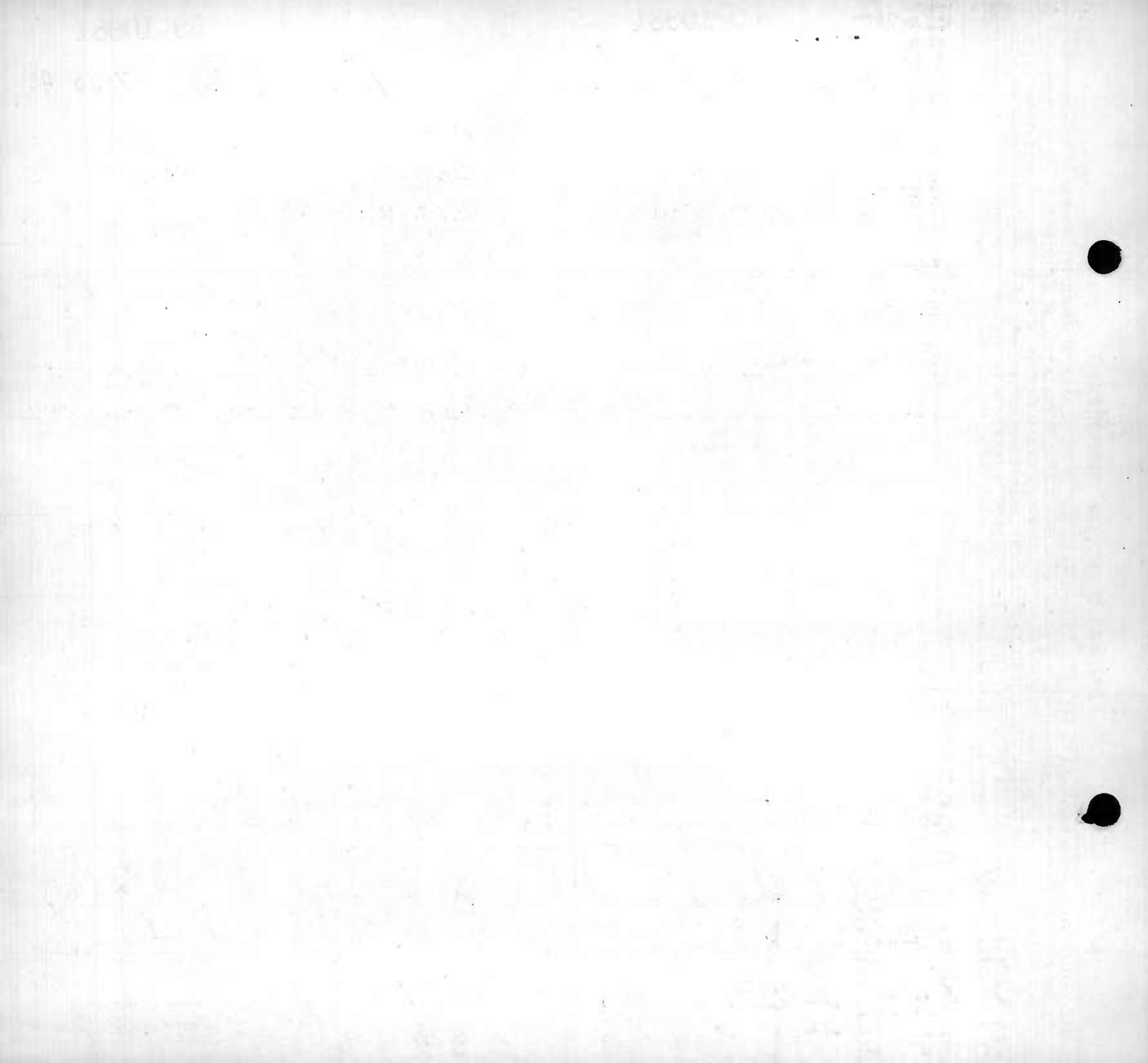
| BALTIMORE CITY HEALTH DEPARTMENT   |   |   |  | REG. NO. <b>69 10980</b>  |
|--|---|---|--|---|
| <b>F-632</b>   |   | <b>69 10980</b>   |  | <b>CERTIFICATE OF DEATH</b>   |
| BIRTH NO.  |   | 1. NAME OF DECEASED<br>(Type or Print) <b>ELEANOR FREITAG</b>   |  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |   | 2. DATE AND HOUR OF DEATH<br><b>NOV. 3, 1969 3<sup>25</sup> P. M.</b>   |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>31 BALTO. CITY HOSP</b>   |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>BALTO.</b>                        |  |   |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |   | C. CITY OR TOWN <b>ESSEX</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                     |  |   |
|  |   | E. STREET AND NUMBER <b>534 RIVERSIDE DR.</b>   |  |   |
| 5. SEX <b>F</b>  | 6. RACE <b>W</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12/1/06</b>                                   | 9. AGE (In years last birthday)<br><b>62</b>  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>TAILOR</b>   |   | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>MD.</b>   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 13. FATHER'S NAME<br><b>JOHN HENRY ZULAU</b>  |  |   |
| 14. MOTHER'S MAIDEN NAME<br><b>?</b>   |   | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>UNK.</b>                                     |  |   |
| 16. SOCIAL SECURITY NO.<br><b>217-16-1859</b>  |   | 17. INFORMANT<br><b>FRANK FREITAG SR.</b>   |  |   |
| 18. ADDRESS<br><b>ABOVE</b>  |   | 19. CAUSE OF DEATH  |  |   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><b>412.21 x 174X</b>   |   | CARDIAC FAILURE   |  |   |
| (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)   |   | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>HYPERTENSIVE HEART DISEASE</b>   |  |   |
| ANTECEDENT CAUSES  |   | (B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>4 YRS</b>   |  |   |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |   | (C) _____   |  |   |
| II   |   | CARCINOMA OF BREAST   |  |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |   | 3 MO.   |  |   |
| 19A. DATE OF OPERATION<br><b>9/26/69</b>   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>CARCINOMA OF BREAST</b>                            | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |   |
| 21D. TIME OF INJURY (APPROX.)  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?  |  |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>JAN 3, 1969</b> to <b>NOV. 3, 1969</b> , that (I) (we) last saw the deceased alive on <b>OCT. 31, 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |   |   |  |   |
| 23A. SIGNATURE<br><b>Joseph Miceli M.D.</b>  |   | 23B. DATE SIGNED<br><b>11/4/69</b>  |  | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |
| 23C. PHYSICIAN'S NAME (Type)<br><b>JOSEPH MICELI M.D.</b>  |   | 23D. ADDRESS<br><b>108 S. TAYLOR AVE ESSEX, MD. 21221</b>   |  |   |
| 24A. BURIAL CREMATION REMOVAL (Specify)<br><b>BURIAL</b>   | 24B. DATE<br><b>11/6/69</b>   | 24C. NAME OF CEMETERY or CREMATORY<br><b>OAK LAWN</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>BALTO. MD.</b>  |
| 25A. NAME OF FUNERAL HOME  |   | 25B. NAME OF REGISTRAR<br><b>J. J. CONNELLY</b>   |  |   |
| 25C. FUNERAL DIRECTOR<br><b>J. J. CONNELLY</b>   |   | ADDRESS<br><b>300 N. W. 10th St.</b>  |  |   |



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| D-240 69 10981   |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | REG. NO. 69 10981   |  |
| BIRTH NO.  |  | 1. NAME OF DECEASED<br>(Type or Print) <u>Helen M. Dashiell</u>  |  | 2. DATE AND HOUR OF DEATH<br><u>Nov. 5, 1969</u> <u>7:00 A.M.</u>                             |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>Md.</u> B. COUNTY <u>1510</u>                                       |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>4402 Whiteoak Ave.</u><br><u>Baltimore, Md.</u>   |  | C. CITY OR TOWN<br><u>Baltimore</u>  |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 5. SEX <u>F.</u> 6. RACE <u>W</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                 |  | 8. DATE OF BIRTH<br><u>4/2/1879</u>   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Secretary</u>  |  | 10B. KIND OF BUSINESS OR INDUSTRY<br>—   |  | 9. AGE (In years last birthday)<br><u>90</u>  |  |
| 13. FATHER'S NAME<br><u>Oscar Dashiell</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>Jane Holbrook</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>NO</u>  |  | 16. SOCIAL SECURITY NO.<br><u>212-32-1245</u>  |  | 17. INFORMANT<br><u>John H. Dashiell Jr.</u>  |  |
| 18. <u>412.314-157.9</u>   |  | CAUSE OF DEATH   |  | ADDRESS<br><u>160 Sillery Bay Pasadena, Md.</u>   |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)   |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><u>Arterio-sclerotic Heart Disease</u>  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>5 yrs.</u>                                 |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |  | (B) <u>Carcinoma of Pancreas</u>   |  | <u>6 months</u>   |  |
|  |  | (C) —  |  |   |  |
| II   |  | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><u>Generalized Arterio Sclerosis</u> |  |   |  |
| 19A. DATE OF OPERATION<br><u>0</u>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Feb. 21st</u> 19 <u>63</u> to <u>Nov. 5</u> 19 <u>69</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>Oct. 28th</u> 19 <u>69</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death. |  |  |  |   |  |
| 23A. SIGNATURE<br><u>Earl L. Chambers</u>  |  | 23B. DATE SIGNED<br><u>11/5/69</u>   |  | 23C. PHYSICIAN'S NAME (Type)<br><u>Earl L. Chambers</u>                                       |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 24B. DATE<br><u>11/8/69</u>  |  | 24C. NAME OF CEMETERY or CREMATORY<br><u>Druid Ridge Cemetery</u>                             |  |
| 24D. LOCATION (City, town, or county)<br><u>Balto</u>  |  | 24E. STATE<br><u>Md.</u>   |  | 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 7 1969</u>  |  |
| 25B. NAME OF REGISTRAR<br><u>John E. ...</u>   |  | 25C. FUNERAL DIRECTOR<br><u>Singleton Funeral Home</u>   |  | 25D. ADDRESS<br><u>1100 ...</u>   |  |



BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mrs Ada May Kennard

2. DATE AND HOUR OF DEATH

11-5-69 1 15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore city Hospitals  
4940 EASTERN AVENUE BALTIMORE, MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission)

Md. 7410.00. 5300  
B. COUNTY

C. CITY OR TOWN

Balto -

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

5 Jonquil Lane 21220

5. SEX

Female

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH

6-8-10

9. AGE (In years last birthday)

59 Yrs

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Waitress

10B. KIND OF BUSINESS OR INDUSTRY

waitress

11. BIRTHPLACE (State or foreign country)

Pa -

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Hiram Shipley dec.

14. MOTHER'S MAIDEN NAME

Laura - A LEASURE

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

178-28-8581

17. INFORMANT

Conner Funeral Home, Everett, Penna.

ADDRESS

18.

2257 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

Poss. Pulmonary emboli  
Post op. (Rt. acoustic neuroma)

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C).....

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

10/21/69

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

Rt. acoustic Neuroma

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (A) (this hospital) attended the deceased from Oct 6, 19 69 to 11-5 19 69, that (X) (we) last saw the deceased alive on 11-5 19 69 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Mehdi Surkarati, M.D.

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

11/5/69

23C. PHYSICIAN'S NAME (Type)

Mehdi Surkarati M.D.

23D. ADDRESS

Baltimore city Hosp 21224  
4940 Eastern Avenue Baltimore, Maryland

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11-7-69

24C. NAME of CEMETERY or CREMATORY

Union Memorial Hospital

24D. LOCATION (City, town, or county) (State)

EAST. PROR. Twp. Bed. Co. Penna.

25A. DATE REC'D BY HEALTH DEPT.

NOV 7 1969

25B. NAME OF REGISTRAR

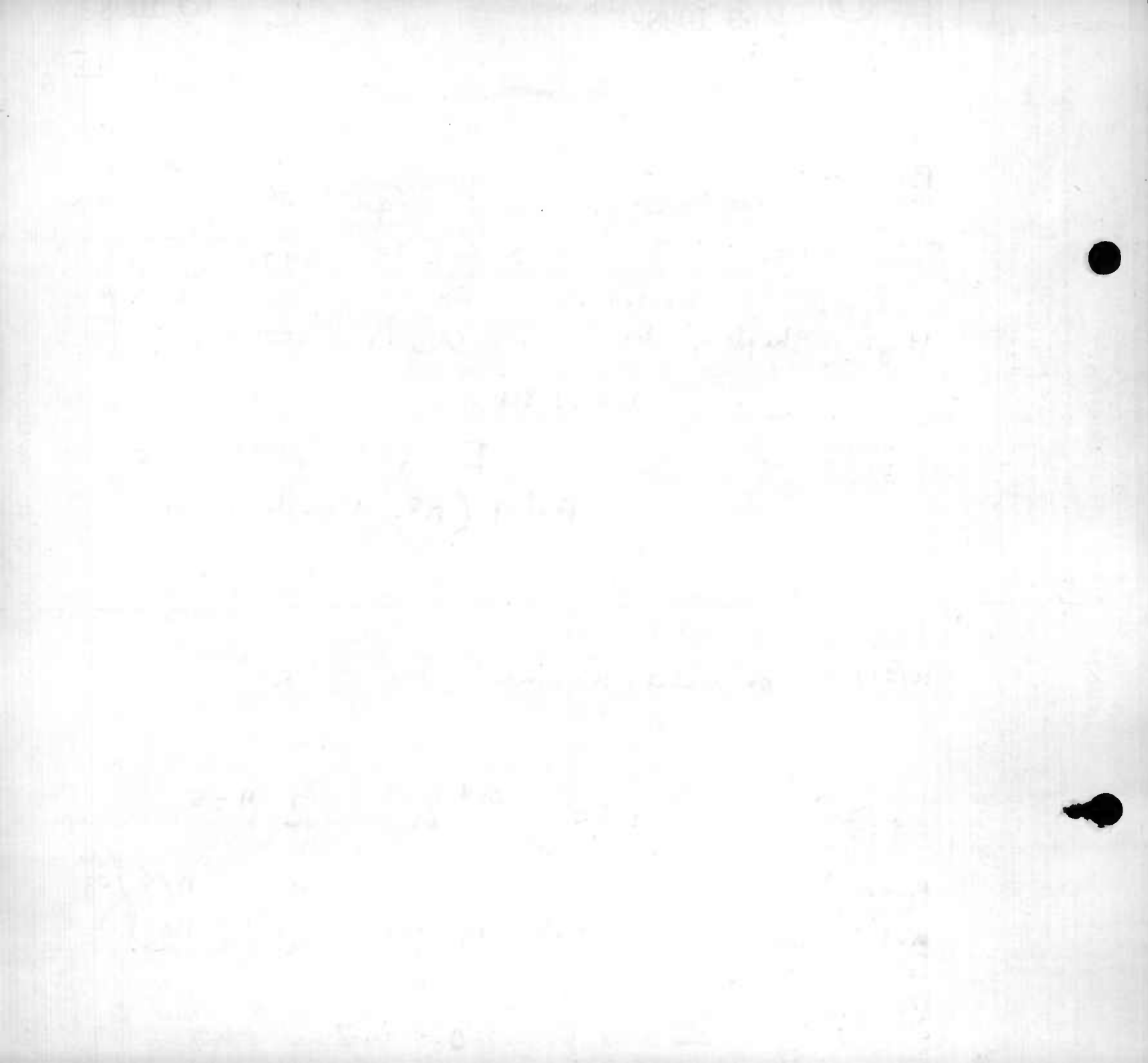
Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

1050 York Rd  
Towson, Md 21204

ADDRESS

1050 York Rd  
Towson, Md 21204



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |   |   |   |  |   |
|--|---|---|---|--|---|
| M-216 69 10983   |   | BALTIMORE CITY HEALTH DEPARTMENT<br><b>CERTIFICATE OF DEATH</b>   |   | REG. NO. 69 10983  |   |
| BIRTH NO.  |   | 1. NAME OF DECEASED<br>(Type or Print) <i>McParland, LEONA S.</i>   |   | 2. DATE AND HOUR OF DEATH<br><i>Nov - 5 - 69 11:40 A.M.</i>    |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |   |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>South Baltimore General</i>   |   |   | A. STATE <i>Md</i> B. COUNTY <i>Harford</i>   |  |   |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |   |   | C. CITY OR TOWN <i>DARLINGTON</i>   |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| E. STREET AND NUMBER<br><i>326 FLINTVILLE RD.</i>  |   |   |   |  |   |
| 5. SEX<br><i>F</i>   | 6. RACE<br><i>W</i>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>1/25/30</i>  | 9. AGE (In years last birthday)<br><i>39</i>                   | If Under 1 Yr. Months Days If Under 24 Hrs. Min.  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>HOUSEWIFE</i>  |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Home</i>  |   | 11. BIRTHPLACE (State or foreign country)<br><i>New Jersey</i> |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |   | 13. FATHER'S NAME<br><i>Edward C. Liebermann</i>  |   | 14. MOTHER'S MAIDEN NAME<br><i>Charlotte Rosenstengel</i>      |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |   | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br><i>Spearing Funeral Home Park Ridge N.J.</i>  |   |
| 18. <i>239.11</i>  |   | CAUSE OF DEATH  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   |   | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><i>SHOCK</i>  |   |  |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |   | (B) <i>PULMONARY Embolism.</i>  |   | (C) _____  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |   | <i>ADRENAL TUMOR</i>  |   |  |   |
| 19A. DATE OF OPERATION<br><i>10/28/69</i>  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>ADRENAL TUMOR</i>                                  | 20A. AUTOPSY? (Yes or No)<br><i>Yes</i>   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                  |  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) <input type="checkbox"/>   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |  |   |
| 21D. TIME OF INJURY (APPROX.)<br>1 Month ( ) Day ( ) Year ( ) Hour ( )   | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?  |   |  |   |
| 22. I certify that (1) (this hospital) attended the deceased from <i>9/22/69</i> to <i>11/5/69</i> and that (1) (we) last saw the deceased alive on <i>11/5</i> 19 <i>69</i> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. |   |   |   |  |   |
| 23A. SIGNATURE<br><i>Thomas N. Shawley M.D.</i>  |   | 23B. DATE SIGNED<br><i>Nov 5, 1969</i>  |   | 23C. PHYSICIAN'S NAME (Type)                                   |   |
| 23D. ADDRESS   |   |   |   |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   | 24B. DATE<br><i>11-5-69</i>   | 24C. NAME OF CEMETERY OR CREMATORY  | 24D. LOCATION (City, town, or county) (State)<br><i>Park Ridge N.J.</i>               |  |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>NOV 7 1969</i>   | 25B. NAME OF REGISTRAR<br><i>Robert E. Gable, M.D.</i>  | 25C. FUNERAL DIRECTOR<br><i>1050 South Brooks Towson</i>  |   |  |   |

11/26/69 - Verification from So. Baltimore General Hospital,

Medical Records.

*SGC.*



W-560

69 10984 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 10984

BIRTH NO.

|   |  |   |  |
|---|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) Clark Weimer   |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> M.   |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>South Balto. General Hospital (DOA)   |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br>November 4, 1969 9:25 P.M.  |  |
| 6. SEX Male   |  | 7. RACE White   |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | C. CITY OR TOWN<br>Gambilla   |  |
| 9. DATE OF BIRTH<br>June 10, 1933   |  | 10. AGE (In years lost birthday) 36<br>If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.   |  |
| 11. BIRTHPLACE (State or foreign country)<br>Chicago, Ill.  |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 13. FATHER'S NAME<br>Harry Weimer   |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>forman  |  |
| 15. MOTHER'S MAIDEN NAME<br>Hannah Clark  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>yes Korean Conflict  |  |
| 17. SOCIAL SECURITY NO.<br>342-26-3245  |  | 18. INFORMANT<br>Moeller-Hallerman Funeral Home   |  |
| 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>Multiple traumatic injuries<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 20A. DATE OF OPERATION  |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 21. AUTOPSY? (Yes or No)<br>yes   |  | 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |
| 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>street  |  | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br>Pottee St. Exit #3 of Harbor Tunnel   |  |
| 22D. TIME (Month) (Day) (Year) (Hour) (APPROX.) Nov. 4, 1969 8:50 P.M.  |  | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |
| 22F. HOW DID INJURY OCCUR? (Passenger)<br>Subject in truck which struck rail and overturned.  |  | 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |
| 24. BURIAL CREMATION, REMOVAL (Specify)<br>Removal-Burial   |  | 24B. DATE<br>11/8/69  |  |
| 24C. NAME OF CEMETERY or CREMATORY<br>Irving Park Cemetery  |  | 24D. LOCATION (City, town, or county) (State)<br>Chicago Cooke Ill.   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 7 1969   |  | 25B. NAME OF REGISTRAR<br>Robert E. Fisher, M.D.  |  |
| 25C. FUNERAL DIRECTOR<br>Beverly E. Hopping   |  | 25D. ADDRESS<br>HOPPING FUNERAL HOME - Annapolis, Md.   |  |

CS 10884

WORLD BANK RESEARCH CENTER

CS 10884

Paul H. Heston

| 69 10985  |  | BALTIMORE CITY HEALTH DEPARTMENT |   | 69 10985 |  |
|---|--|----------------------------------|---|----------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                                  |   | REG. NO. |  |
| BIRTH NO.   |  |                                  |   |          |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Edward Miller</b>   |  |                                  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month <b>11</b> Day <b>4</b> Year <b>69</b> Hour <b>2:00 a.m.</b><br>Estimated <input type="checkbox"/> |          |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(If not in hospital or institution, give street address or location)<br><b>1838 E. Madison Ave.</b>   |  |                                  | 3. DATE PRONOUNCED DEAD<br>Month <b>11</b> Day <b>4</b> Year <b>69</b> Hour <b>2:00 a.m.</b>  |          |  |
| 6. SEX <b>male</b>  |  |                                  | 7. RACE <b>colored</b>  |          |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |                                  | C. CITY OR TOWN <b>Baltimore</b>  |          |  |
| 9. DATE OF BIRTH <b>MAY 12, 1933</b>  |  |                                  | 10. AGE (In years last birthday) <b>36</b>  |          |  |
| 11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>   |  |                                  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |          |  |
| 13. FATHER'S NAME <b>CHARLES MILLER</b>   |  |                                  | 14. MOTHER'S MAIDEN NAME <b>VERA JONES</b>  |          |  |
| 15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PRODUCE LOADER</b>  |  |                                  | 16. KIND OF BUSINESS OR INDUSTRY <b>BUSINESS</b>  |          |  |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>   |  |                                  | 18. SOCIAL SECURITY NO. <b>219-30-5229</b>  |          |  |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>E966X</b>  |  |                                  | 20. CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <b>Multiple stab wounds</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) _____<br>(C) _____                                    |          |  |
| 21. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A):</b>   |  |                                  | 22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |          |  |
| 23. DATE OF OPERATION <b>2</b>  |  |                                  | 24. CONDITION FOR WHICH OPERATION WAS PERFORMED   |          |  |
| 25. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING  |  |                                  | 26. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>   |          |  |
| 27. TIME OF INJURY (APPROX.) <b>11 4 69 1:45 a.m.</b>   |  |                                  | 28. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |          |  |
| 29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>1838 E. Madison Ave. 1403</b>  |  |                                  | 30. HOW DID INJURY OCCUR? <b>stabbed during altercation</b>   |          |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                  |   |          |  |
| ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>   |  |                                  | DATE SIGNED <b>11/4/69</b>  |          |  |
| EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>   |  |                                  | ASSOCIATE MEDICAL EXAMINER  |          |  |
| 24A. BURIAL OR REMOVAL <b>BURIAL</b>  |  |                                  | 24B. DATE <b>11-8-69</b>  |          |  |
| 24C. NAME OF CEMETERY or CREMATORY <b>MT. AUBURN CEM.</b>   |  |                                  | 24D. LOCATION (City, town, or county) (State) <b>WESTPORT Md.</b>   |          |  |
| 25A. DATE REC'D BY HEALTH DEPT. <b>NOV 7 1969</b>   |  |                                  | 25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>  |          |  |
| 25C. FUNERAL DIRECTOR <b>Calvin S. Scruggs</b>  |  |                                  | ADDRESS <b>1412 E. Preston St.</b>  |          |  |

NO  
Produce Order  
Business  
N. 217.  
Charles Miller  
514-30-2554 Mr. William Miller  
Jesse Jones  
1204  
Elmwood St.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |                             |  |   | REG. NO. <b>69 10986</b>   |
|--|-----------------------------|--|---|--|
| <div style="display: flex; justify-content: space-between;"> <span><b>C-460</b></span> <span><b>69 10986</b></span> <span><b>X</b></span> </div> <div style="display: flex; justify-content: space-between;"> <span><b>BIRTH NO. <i>La Plata, Md.</i></b></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>   |                             |  |   |  |
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>BABY BOY COLLIER</b>  |                             | 2. DATE AND HOUR OF DEATH<br><b>NOVEMBER 5, 1969 10:16 P.M.</b>  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>JOHNS HOPKINS HOSPITAL<br/>3305 S. BALTIMORE, MO. 21205</b>  |                             | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>CHARLES</b><br>C. CITY OR TOWN <b>LA PLATA</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>P.O. Box 185, LA PLATA, MO.</b> |   |  |
| 5. SEX<br><b>MALE</b>  | 6. RACE<br><b>CAUCASIAN</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>NOV. 3, 1969</b> | 9. AGE (In years lost birthday)<br><b>3</b>  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>INFANT</b>   |                             | 10B. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)<br><b>PHYSICIANS MEMORIAL HOSP. LA PLATA, M.D.</b> |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>   |                             | 13. FATHER'S NAME<br><b>LARRY E. COLLIER</b>   |   |  |
| 14. MOTHER'S MAIDEN NAME<br><b>CATHERINE</b>   |                             | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>  |   |  |
| 16. SOCIAL SECURITY NO.  |                             | 17. INFORMANT<br><b>LEE NEIDENGAARD, M.D.</b>  |   |  |
| 18. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL BALTIMORE, MD. 21205</b>  |                             |  |   |  |
| 19. CAUSE OF DEATH<br><b>74-3.9 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>APNEIC SPELL</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>SEVERE CONGENITAL NEUROLOGIC ANOMALIES ASSOCIATED WITH PROBABLE TRISOMY GROUP D</b> |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>15 MIN</b>  |   |  |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>HYPOGLYCEMIA, RENAL INSUFFICIENCY</b>   |                             |  |   |  |
| 21A. DATE OF OPERATION<br><b>2</b>   |                             | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 21C. AUTOPSY? (Yes or No)<br><b>YES</b>  |
| 21D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |                             |  |   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)  |                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                     |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                             | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |   | 21F. HOW DID INJURY OCCUR?   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 3 1969</b> to <b>NOVEMBER 5 1969</b> , that (I) (we) lost saw the deceased alive on <b>NOVEMBER 5 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <b>(did)</b> (did not) view the body after death.   |                             |  |   |  |
| 23A. SIGNATURE<br><b>Lee Neidengard M.D.</b>   |                             | 23B. DATE SIGNED<br><b>November 5, 1969</b>  |   | 23C. PHYSICIAN'S NAME (Type)<br><b>L. Neidengard</b>   |
| 23D. ADDRESS<br><b>Johns Hopkins Hospital</b>  |                             |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Cremation</b>   |                             | 24B. DATE<br><b>11/6/69</b>  |   | 24C. NAME OF CEMETERY or CREMATORY<br><b>Johns Hopkins Hospital</b>                          |
| 24D. LOCATION (City, town, or county) (State)<br><b>601 N. Broadway, Balto., Md.</b>   |                             |  |   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 7 1969</b>   |                             | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, Md.</b>   |   | 25C. FUNERAL DIRECTOR<br><b>HOSPITAL DISPOSAL</b>  |
| 25D. ADDRESS   |                             |  |   |  |

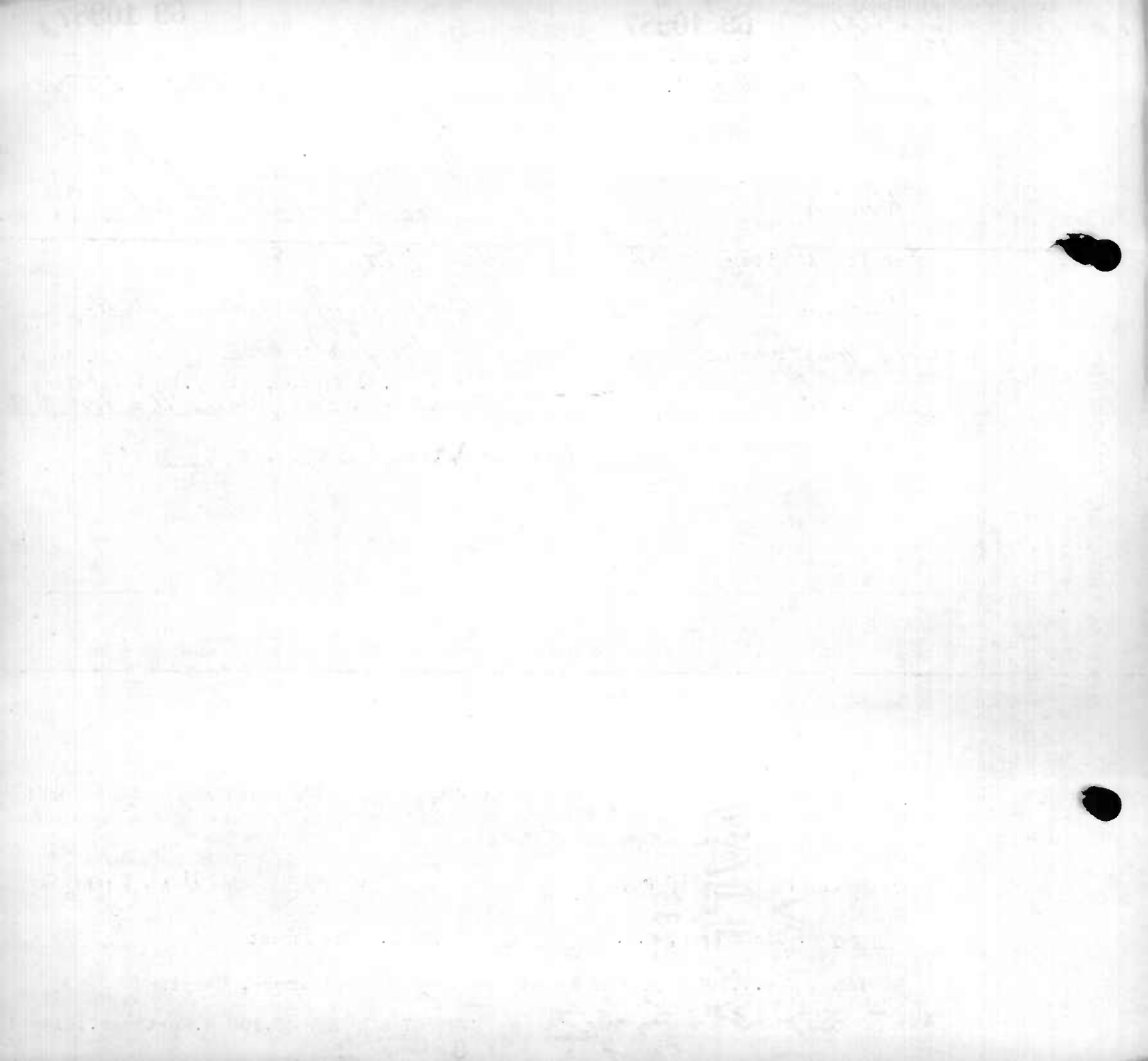
11/10 Called hospital La Plata, Md. is  
closed. No indication on hospital  
records as to the county. CT.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |  |   |  | REG. NO. <span style="float: right;">69 10987</span>  |  |
|---|--|---|--|---|--|
| BIRTH NO. <span style="float: right;">B-400</span>  |  | 69 10987  |  | CERTIFICATE OF DEATH  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Emma Maude Ballou</i>   |  | 2. DATE AND HOUR OF DEATH<br><i>Nov - 4 - 1969 1<sup>12</sup> 15 M.</i>   |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY <i>2714</i> |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>91 Kewick</i>  |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |  | C. CITY OR TOWN <i>Baltimore - Md.</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 5. SEX <i>Female</i>  |  | 6. RACE <i>White</i>  |  | 8. DATE OF BIRTH <i>4-2-1874</i>  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. AGE (in years last birthday) <i>95</i>   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>                       |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland, U.S.A.</i>  |  |
| 13. FATHER'S NAME <i>John Hertzman (JOHN STARTZMAN)</i>   |  | 14. MOTHER'S MAIDEN NAME <i>Mary Jackson (MARY JACKSON)</i>   |  |   |  |
| 15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>   |  | 16. SOCIAL SECURITY NO. <i>212-56-7180</i>  |  | 17. INFORMANT <i>J.B. Winter, Atty. 1201 Fidelity Kewick Records Wayne Winter R.N.</i>  |  |
| 18. <i>412.41</i>   |  | CAUSE OF DEATH  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>9 yrs</i>   |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)  |  | A. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerotic Cardiovascular Disease</i>                                       |  |   |  |
| ANTECEDENT CAUSES   |  | B. DUE TO, OR AS A CONSEQUENCE OF:  |  |   |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |  | C. DUE TO, OR AS A CONSEQUENCE OF:  |  |   |  |
| II  |  |   |  |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |   |  |   |  |
| 19A. DATE OF OPERATION <i>0</i>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)   |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                  |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>21 Mar 1960</i> to <i>4 Nov 1969</i> , that (I) (we) last saw the deceased alive on <i>4 Nov 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |   |  |   |  |
| 23A. SIGNATURE <i>Aubrey D. Richardson M.D.</i>   |  |   |  | 23B. DATE SIGNED <i>4 Nov 1969</i>  |  |
| 23C. PHYSICIAN'S NAME (Type) <i>Aubrey D. Richardson, M.D.</i>  |  |   |  | 23D. ADDRESS <i>700 W. 40th Street</i>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>  |  | 24B. DATE <i>Nov. 7, 1969</i>   |  | 24C. NAME OF CEMETERY or CREMATORY <i>Green Mount Cemetery</i>  |  |
| 24D. LOCATION (City, town, or county) <i>Baltimore, Maryland</i>  |  | 24E. NAME OF REGISTRAR <i>Robert E. Fisher M.D.</i>   |  | 24F. FUNERAL DIRECTOR <i>STEWART &amp; MOWEN CO.</i>  |  |
| 24G. DATE REC'D BY HEALTH DEPT. <i>NOV 7 1969</i>   |  | 24H. NAME OF REGISTRAR <i>Robert E. Fisher M.D.</i>   |  | 24I. FUNERAL DIRECTOR <i>STEWART &amp; MOWEN CO.</i>  |  |
| 24J. ADDRESS <i>108 W. North Av., City 1</i>  |  |   |  |   |  |





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                             |   |   | REG. NO. <b>69 10988</b>   |
|---|-----------------------------|---|---|--|
| BIRTH NO. <b>69 10988</b> <b>CERTIFICATE OF DEATH</b>   |                             |   |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>JOHN H. PREISINGER</b>  |                             | 2. DATE AND HOUR OF DEATH<br><b>NOV 5, 1969</b> <b>330 P M.</b>   |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                             | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before omission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>2745</b>                      |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>6407 FAIRDEL AVE</b><br><b>BALTO MD</b>   |                             | C. CITY OR TOWN<br><b>BALTIMORE</b>   | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 5. SEX<br><b>MALE</b>   | 6. RACE<br><b>WHITE</b>     | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>FEB 12 1894</b>  | 9. AGE (In years last birthday)<br><b>75</b>                             |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>BAKER</b>   |                             | 10B. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country)<br><b>GERMANY</b>              |
| 13. FATHER'S NAME<br><b>HENRY PREISINGER</b>  |                             | 14. MOTHER'S MAIDEN NAME<br><b>HEROLD</b>   |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |                             | 16. SOCIAL SECURITY NO.<br><b>913-059496</b>  |   | 17. INFORMANT<br><b>MARGARET PREISINGER</b>                              |
| 18. <b>162.1 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury at complication which caused death.)<br><b>Carcinoma of Lung</b>  |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 yrs</b>  |   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                             | (B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                             |   |   |  |
| 19A. DATE OF OPERATION  |                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                             | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |   | 21F. HOW DID INJURY OCCUR?   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Jan. 1967</b> to <b>Nov 5 1969</b> , that (I) (we) last saw the deceased alive on <b>Nov 5 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                             |   |   |  |
| 23A. SIGNATURE<br><b>MW JACOBSON MD</b>   |                             |   | 23B. DATE SIGNED<br><b>11-6-69</b>  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>M. W. JACOBSON MD</b>  |                             |   | 23D. ADDRESS<br><b>6810 Park Heights Ave Balto MD</b>   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 24B. DATE<br><b>11/8/69</b> | 24C. NAME OF CEMETERY or CREMATORY<br><b>BALTIMORE CEMETERY NORTH AVE BALTO MD</b>  |   | 24D. LOCATION (City, town, or county) (State)                            |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 7 1969</b>  |                             | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor MD</b>  |   | 25C. FUNERAL DIRECTOR<br><b>Frederick J. ... 7200 ...</b>                |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |           |   |  | REG. NO. 69 10989  |   |
|--|-----------|---|--|--|---|
| BIRTH NO. 69 10989   |           |   |  |  |   |
| 1. NAME OF DECEASED<br>(Type or Print) FAINE, BARNEY   |           |   | 2. DATE AND HOUR OF DEATH<br>10-25-69 16 10 A. M.  |  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>NORTH CHARLES GEN. HOSP.<br>49  |           |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE MARYLAND 21211 1306<br>C. CITY OR TOWN Baltimore<br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER 3531 FALLS ROAD |  |   |
| 5. SEX M   | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-4-83   | 9. AGE (In years last birthday) 86                                       | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxicab Co |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |           |   | 11. BIRTHPLACE (State or foreign country) Russia   |  | 12. CITIZEN OF WHAT COUNTRY U.S.A.  |
| 13. FATHER'S NAME Victor FAINE   |           |   | 14. MOTHER'S MAIDEN NAME   |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes Korea I   |           |   | 16. SOCIAL SECURITY NO. 084-01-5528  |  | 17. INFORMANT MCGH. ADDRESS   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>I<br>410.9<br>CAUSE OF DEATH<br>Myocardial Infarction<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>Arteriosclerotic Heart<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>Disease<br>(C) _____<br>Pneumonia Encephalitis |           |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Days   |  |   |
| MEDICAL CERTIFICATION<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br>II<br>Pneumonia Encephalitis  |           |   |  |  |   |
| 19A. DATE OF OPERATION   |           | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |           | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |           | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from 10-15 1969 to 10-25 1969 that (I) (we) last saw the deceased alive on 10-25 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |           |   |  |  |   |
| 23A. SIGNATURE<br>Graham V. Patricia<br>DEGREE   |           |   |  | 23B. DATE SIGNED<br>10/25/69   |   |
| 23C. PHYSICIAN'S NAME (Type)<br>Graham V. Patricia<br>DEGREE   |           |   |  | 23D. ADDRESS<br>MCGH.  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial   |           | 24B. DATE<br>10-27-69   |  | 24C. NAME OF CEMETERY OR CREMATORY<br>Meadowridge                        |   |
| 24D. LOCATION (City, town, or county) (State)<br>Howard Co Dorsey Md.  |           | 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 7 1969   |  |  |   |
| 25B. NAME OF REGISTRAR<br>Robert E. Talbot, M.D.   |           | 25C. FUNERAL DIRECTOR<br>Frank W. Smith 814 136th St  |  |  |   |



F-660

69 10990

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 10990

BIRTH NO.

|  |  |  |  |
|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) GRACE J FEHRER  |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> Nov 6 1969 M.  |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>Union Memorial Hospital (DOA)   |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br>November 6, 1969 8:15 A.M.   |  |
| 6. SEX<br>Female   |  | 7. RACE<br>White   |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | C. CITY OR TOWN<br>Baltimore   |  |
| 9. DATE OF BIRTH<br>2-2-1882   |  | 10. AGE (In years last birthday) 87  |  |
| 11. BIRTHPLACE (State or foreign country)<br>Maryland  |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife   |  | 14B. KIND OF BUSINESS OR INDUSTRY<br>Own Home  |  |
| 15. MOTHER'S MAIDEN NAME<br>Bernadina Schaefer   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>No  |  |
| 17. SOCIAL SECURITY NO.<br>220-48-9815   |  | 18. INFORMANT<br>Mrs. Dolores Moller   |  |
| 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>Arteriosclerotic cardiovascular disease<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 20A. DATE OF OPERATION<br>2  |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 21. AUTOPSY? (Yes or No)<br>Yes  |  |  |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?   |  |  |  |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)  |  | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |
| 22F. HOW DID INJURY OCCUR?   |  |  |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |  |  |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type) Charles S. Springate, M.D.  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |  |
| DATE SIGNED<br>11-6-69   |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial   |  | 24B. DATE<br>11-10-69  |  |
| 24C. NAME OF CEMETERY or CREMATORY<br>Holy Redeemer Cemetery   |  | 24D. LOCATION (City, town, or county) (State)<br>Baltimore Md.   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 7 1969  |  | 25B. NAME OF REGISTRAR<br>Robert E. Taylor, M.D.   |  |
| 25C. FUNERAL DIRECTOR<br>H.W. Jenkins & Sons Co.   |  | ADDRESS<br>4905 York Rd. Baltimore, Md. 21212  |  |

ACADEMY OF BOND

VALLEY

32-14-24 JD  
5-652

69 10991

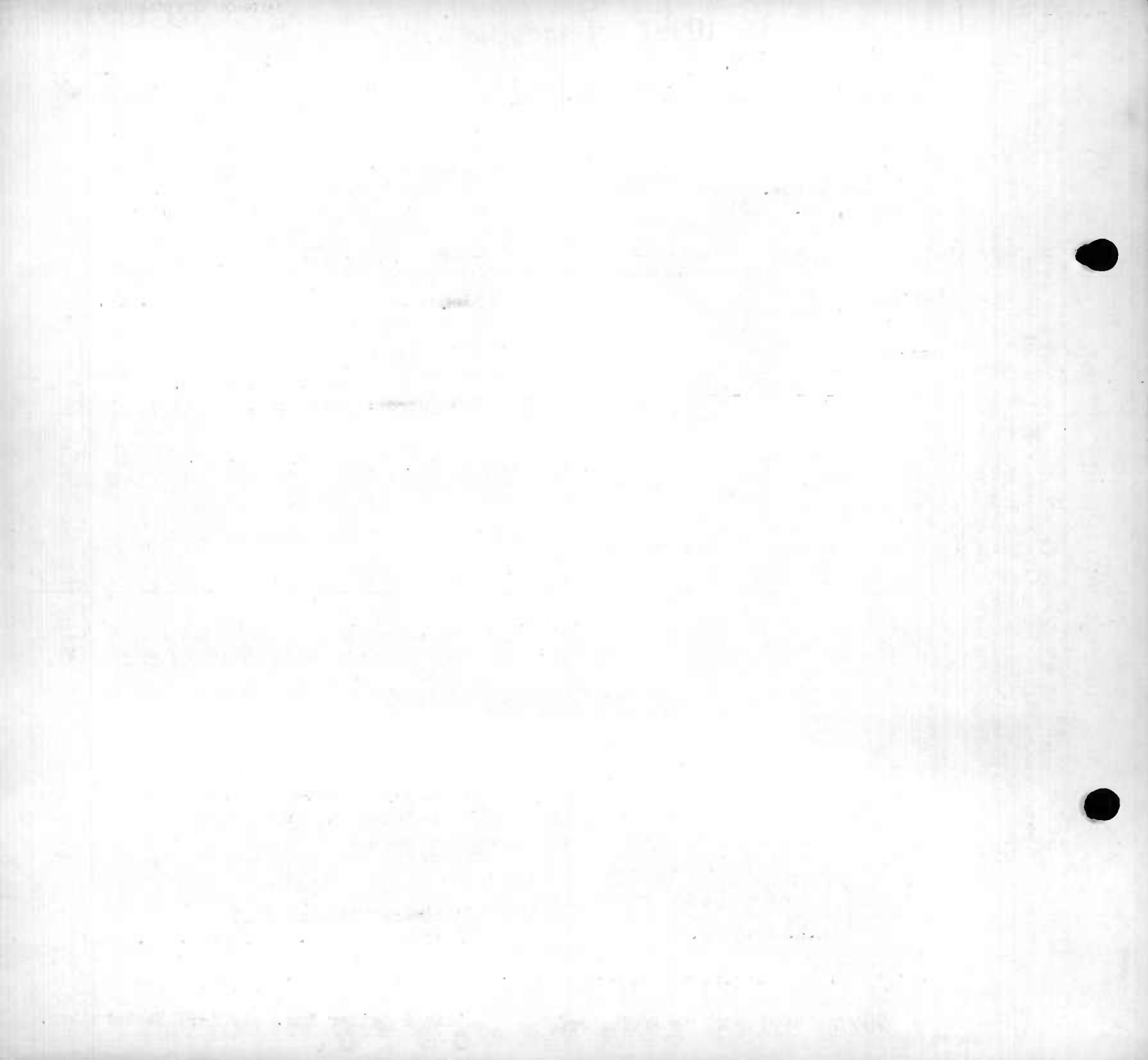
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 10991

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| BIRTH NO.  |  | 1. NAME OF DECEASED<br>(Type or Print) <b>ALLEN H. SORENSON</b>                                      |  | 2. DATE AND HOUR OF DEATH<br><b>11/5/69 15 45 A M.</b>  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD</b><br>B. COUNTY <b>201</b>                         |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>BALTIMORE CITY HOSPITALS</b><br><b>4940 Eastern Ave.</b><br><b>Baltimore, Md. 21224</b>   |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                 |  | C. CITY OR TOWN<br><b>BALTIMORE</b><br>D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                        |  |
| 5. SEX<br><b>Male</b>  |  | 6. RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Cook</b>   |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 8. DATE OF BIRTH<br><b>9-3-98</b>   |  |
| 13. FATHER'S NAME<br><b>Jennis</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Christine</b>   |  | 9. AGE (In years last birthday)<br><b>71</b>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces?<br>(Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes 7-16-42 5-1-43</b>   |  | 16. SOCIAL SECURITY NO.<br><b>210-10-8466-A</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Minnesota</b>   |  |
| 17. INFORMANT<br><b>BCH Records: Baltimore, Md. 21224 #21224</b>   |  | ADDRESS<br><b>4940 Eastern Ave.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 18. <b>4419 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>MYOCARDIAL INFARCTION</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>GENERALIZED ATHEROSCLEROSIS</b><br><b>AORTIC ANEURYSM</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>CHRONIC OCCLUSIVE PULMONARY DISEASE</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>~20 yrs</b> |  |  |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <b>~20 yrs</b>                          |  |
| 19A. DATE OF OPERATION<br><b>0</b>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)             |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |  | 21E. INJURY OCCURRED<br>While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>11/3/69</b> 19 <b>68</b> to <b>11/5</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>11/5</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.  |  |  |  |   |  |
| 23A. SIGNATURE<br><b>R.K. Maza MD</b><br>DEGREE  |  |  |  | 23B. DATE SIGNED<br><b>11/5/69</b>  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>R.K. Maza Md.</b><br>DEGREE   |  |  |  | 23D. ADDRESS<br><b>Baltimore City Hospitals</b><br><b>4940 Eastern Ave. Baltimore, Md. 21224</b>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>11-10-1969</b>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Baltimore National Cemetery Baltimore, Maryland</b>  |  |
| 24D. LOCATION (City, town, or county) (State)  |  | 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 7 1969</b>   |  |   |  |
| 25B. NAME OF REGISTRAR<br><b>Robert E. Tally, M.D.</b>   |  | 25C. FUNERAL DIRECTOR<br><b>Lilly &amp; Zeiler Inc. 1901-07 Eastern Ave.</b>                         |  |   |  |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.





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| BALTIMORE CITY HEALTH DEPARTMENT   |   |  |  | REG. NO. <span style="font-size: 1.2em;">69 10992</span>  |  |
|--|---|--|--|---|--|
| BIRTH NO. <span style="font-size: 1.2em;">69 10992</span>  |   | <b>CERTIFICATE OF DEATH</b>  |  |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <span style="font-size: 1.2em;">DOUGLES CRAWLEY Jr.</span>  |   | 2. DATE AND HOUR OF DEATH<br><span style="font-size: 1.2em;">11-4-69 8<sup>15</sup> P. M.</span>   |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><span style="font-size: 1.5em;">37 MERCY Hospital</span>  |   | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">2201</span>  |  |   |  |
|  |   | C. CITY OR TOWN<br><span style="font-size: 1.2em;">BALTIMORE</span>  |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
|  |   | E. STREET AND NUMBER<br><span style="font-size: 1.2em;">825 S. CHARLES ST.</span>  |  |   |  |
| 5. SEX<br><span style="font-size: 1.2em;">MALE</span>  | 6. RACE<br><span style="font-size: 1.2em;">NEGRO</span> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><span style="font-size: 1.2em;">12-23-35</span>   | 9. AGE (In years last birthday)<br><span style="font-size: 1.2em;">33</span> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |   | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><span style="font-size: 1.2em;">MARYLAND</span>  |  |
| 13. FATHER'S NAME<br><span style="font-size: 1.2em;">DOUGLES CRAWLEY</span>  |   | 14. MOTHER'S MAIDEN NAME<br><span style="font-size: 1.2em;">MARY FLATTS</span>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><span style="font-size: 1.2em;">U.S.A.</span>   |  |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><span style="font-size: 1.2em;">No</span>  |   | 16. SOCIAL SECURITY NO.<br><span style="font-size: 1.2em;">213-32-2627</span>  |  | 17. INFORMANT<br><span style="font-size: 1.2em;">LERAY CRAWLEY</span> ADDRESS<br><span style="font-size: 1.2em;">777 CARROLL ST.</span>   |  |
| 18. <span style="font-size: 1.2em;">703X1</span><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |   | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br><span style="font-size: 1.2em;">Cerebral edema</span><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) <span style="font-size: 1.2em;">Uremia</span><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) <span style="font-size: 1.2em;">Hypertension</span> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><span style="font-size: 1.2em;">hours</span><br><span style="font-size: 1.2em;">months</span><br><span style="font-size: 1.2em;">years</span> |  |
| II   |   |  |  |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |   |  |  |   |  |
| 19A. DATE OF OPERATION<br><span style="font-size: 1.2em;">2</span>   |   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)<br><span style="font-size: 1.2em;">YES</span>   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><span style="font-size: 1.2em;">YES</span>  |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |   | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (this hospital) attended the deceased from <span style="font-size: 1.2em;">10/31</span> 19 <span style="font-size: 1.2em;">69</span> to <span style="font-size: 1.2em;">11/4</span> 19 <span style="font-size: 1.2em;">69</span> that (we) last saw the deceased alive on <span style="font-size: 1.2em;">11/4</span> 19 <span style="font-size: 1.2em;">69</span> and that (in my) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. |   |  |  |   |  |
| 23A. SIGNATURE<br><span style="font-size: 1.2em;">Barredo, M.D.</span>   |   | 23B. DATE SIGNED<br><span style="font-size: 1.2em;">11/5/69</span>   |  | 23C. PHYSICIAN'S NAME (Type)<br><span style="font-size: 1.2em;">BARREDO, M.D.</span>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><span style="font-size: 1.2em;">BURIAL</span>  |   | 24B. DATE<br><span style="font-size: 1.2em;">11-8-69</span>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><span style="font-size: 1.2em;">MT. AUBURN</span>   |  |
| 25A. DATE RECD BY HEALTH DEPT.<br><span style="font-size: 1.2em;">NOV 7 1969</span>  |   | 25B. NAME OF REGISTRAR<br><span style="font-size: 1.2em;">Robert E. Taylor, M.D.</span>  |  | 25C. FUNERAL DIRECTOR<br><span style="font-size: 1.2em;">CHARLES G. ACE</span> ADDRESS<br><span style="font-size: 1.2em;">661 W. BARRE ST.</span>   |  |
| 24D. LOCATION (City, town, or county) (State)<br><span style="font-size: 1.2em;">BALTIMORE, MARYLAND</span>  |   |  |  |   |  |



# FUNERAL DIRECTOR: IMPORTANT

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| BALTIMORE CITY HEALTH DEPARTMENT   |  |   |   | REG. NO. <b>69 10993</b>  |
|--|--|---|---|---|
| BIRTH NO. <b>69 10993</b>  |  | <b>CERTIFICATE OF DEATH</b>   |   |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>John N. Annen</b>  |  | 2. DATE AND HOUR OF DEATH<br><b>1:50 AM. 11/16/69</b> M.  |   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Union Memorial Hospital</b>  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>MD</b> B. COUNTY <b>1203</b>                           |   |   |
|  |  | C. CITY OR TOWN <b>BALTIMORE</b>  |   | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|  |  | E. STREET AND NUMBER <b>316 E 26th SE</b>   |   |   |
| 5. SEX <b>M</b>  | 6. RACE <b>W</b>                                       | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>7/23/03</b>   | 9. AGE (In years last birthday) <b>66</b>   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED</b>  |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>BREWERY WORKER</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>MD</b>  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 13. FATHER'S NAME<br><b>FRANK L. ANNEN</b>  |   |   |
| 14. MOTHER'S MAIDEN NAME<br><b>IE/HA MOFFAT</b>  |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                       |   |   |
| 16. SOCIAL SECURITY NO.<br><b>216-01-4716A</b>   |  | 17. INFORMANT<br><b>MARY E. ANNEN 316 E 26TH ST 21218</b>   |   |   |
| 18. <b>433.9 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Recent cerebral infection</b>   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>D-H</b>  |   |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.   |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:                        |   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |   |   |   |
| 19A. DATE OF OPERATION <b>0</b>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |   | 21F. HOW DID INJURY OCCUR?  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>11/16/1969</b> to <b>11/16/1969</b> , that (I) (we) last saw the deceased alive on <b>11/16/1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |   |   |   |
| 23A. SIGNATURE<br><b>[Signature]</b>   |  | 23B. DATE SIGNED<br><b>11/16/69</b>   |   | 23C. PHYSICIAN'S NAME (Type)<br><b>[Signature]</b>  |
| 23D. ADDRESS<br><b>[Signature]</b>   |  | 23E. ADDRESS<br><b>[Signature]</b>  |   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 24B. DATE<br><b>NOV 10 1969</b>                        | 24C. NAME OF CEMETERY OR CREMATORY<br><b>PARK WOOD CEMETERY</b>   | 24D. LOCATION (City, town, or county) (State)<br><b>TAYLOR AVE BALTO MD</b> |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 7 1969</b>   | 25B. NAME OF REGISTRAR<br><b>Robert E. [Signature]</b> | 25C. FUNERAL DIRECTOR<br><b>THE DIAPREY BROS INC 7110 BELAIR RD</b>   | 25D. ADDRESS<br><b>[Signature]</b>  |   |

When Memorial Day is observed

✓

FRANK C. HARRIS

FRANK C. HARRIS

FRANK C. HARRIS

FRANK C. HARRIS

(D.H.)

FRANK C. HARRIS

FRANK C. HARRIS

FRANK C. HARRIS

FRANK C. HARRIS

FRANK C. HARRIS

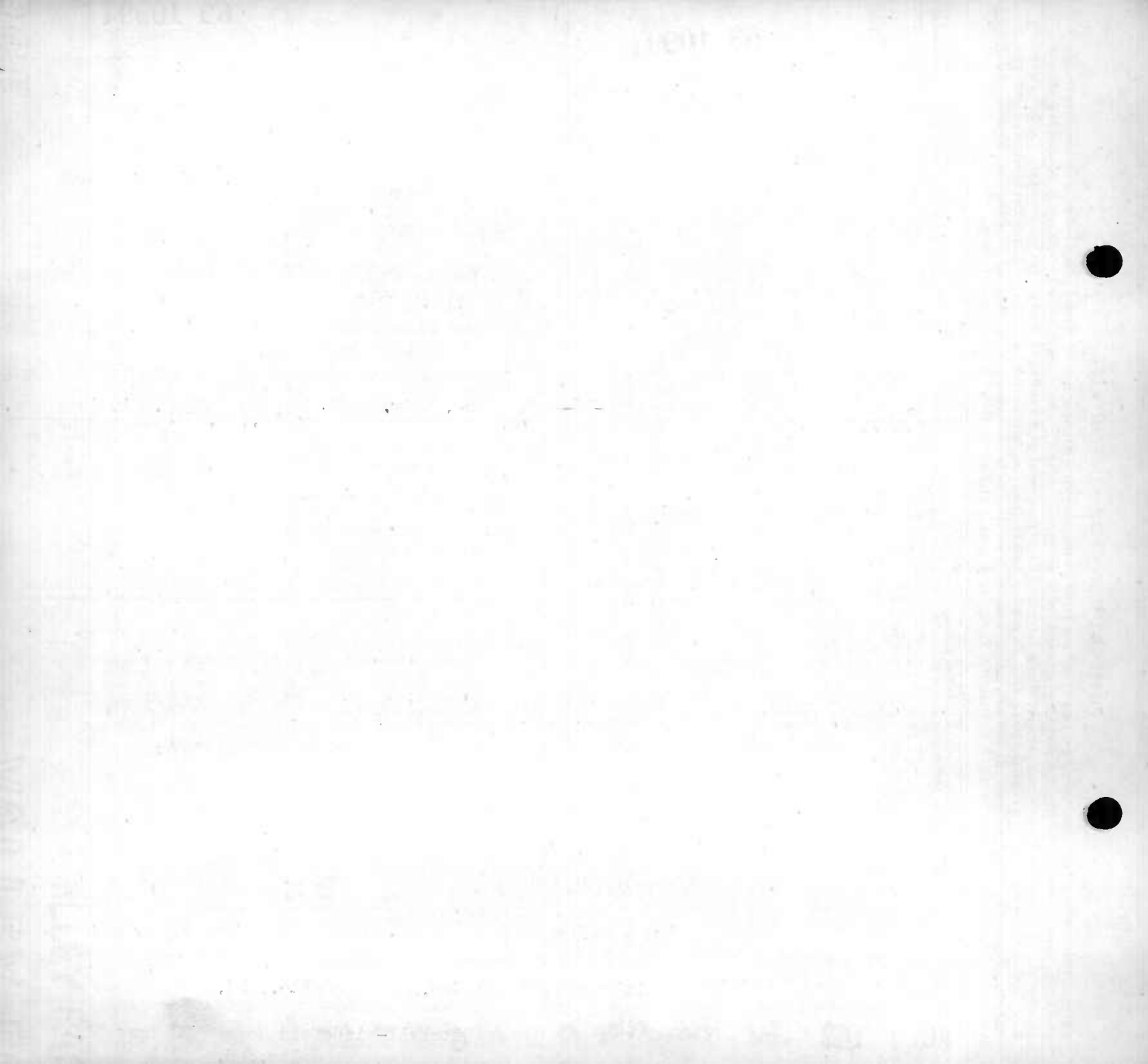
FRANK C. HARRIS

FRANK C. HARRIS

# FUNERAL DIRECTOR: IMPORTANT

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|   |                         |   |  |   |  |  |  |   |  |
|---|-------------------------|---|--|---|--|--|--|---|--|
| B-421   |                         | 69 10994  |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | 69 10994   |  | REG. NO.  |  |
| BIRTH NO.   |                         | 1. NAME OF DECEASED<br>(Type or Print) <i>Irma Grace Blackburn</i>  |  |   |  | 2. DATE AND HOUR OF DEATH<br><i>11/4/69</i> <i>9 30</i> P. M.  |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                         |   |  |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY <i>2748</i>  |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>BON SECOURS HOSPITAL</i>   |                         |   |  |   |  | C. CITY OR TOWN<br><i>Baltimore</i>  |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| ADDRESS<br><i>34 BALTIMORE, Md. 21223</i>   |                         |   |  |   |  | E. STREET AND NUMBER<br><i>1402 LOCHNER Rd. Apt A.</i>   |  |   |  |
| 5. SEX<br><i>FEMALE</i>   | 6. RACE<br><i>WHITE</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><i>5/10/01</i>  | 9. AGE (In years last birthday)<br><i>68</i> | If Under 1 Yr. Months Days   |  | If Under 24 Hrs. Hours Min.   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>LINATYPE OPR.</i>   |                         |   |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><i>MARYLAND</i>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  |
| 13. FATHER'S NAME<br><i>JOSEPH SMITH</i>  |                         |   |  | 14. MOTHER'S MAIDEN NAME<br><i>MARY DEAN</i>  |  |  |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>no</i>   |                         |   |  | 16. SOCIAL SECURITY NO.<br><i>219-16-9181</i>   |  | 17. INFORMANT<br><i>Mrs. Shirley Clodfelter</i>  |  |   |  |
|   |                         |   |  | ADDRESS<br><i>1230 E. Gittings Ave. Balto., Md. 21212</i>   |  |  |  |   |  |
| 18. <i>4/10.9</i> I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                         |   |  |   |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><i>Myocardial infarction one day</i><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF: |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |                         |   |  |   |  |  |  |   |  |
| 19A. DATE OF OPERATION<br><i>0</i>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><i>No</i>  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |  |  |  |   |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)  |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |  |  |  |   |  |
| 22. I certify that <i>(I)</i> (this hospital) attended the deceased from <i>10/31/1969</i> to <i>11/4/1969</i> , that <i>(I)</i> (we) lost the deceased alive on <i>11/4/1969</i> and that <i>in</i> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                    |                         |   |  |   |  |  |  |   |  |
| 23A. SIGNATURE<br><i>Orattai Thirawat M.D.</i>  |                         |   |  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |  | 23B. DATE SIGNED<br><i>11/4/69</i>   |  |   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><i>ORATTAI THIRAWAT MD</i>  |                         |   |  | 23D. ADDRESS<br><i>BON SECOURS HOSPITAL Balto.</i>  |  |  |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>burial</i>   |                         | 24B. DATE<br><i>11/7/69</i>   |  | 24C. NAME of CEMETERY or CREMATORY<br><i>Baltimore National Cem.</i>  |  | 24D. LOCATION (City, town, or county) (State)<br><i>Balto., Md.</i>  |  |   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>NOV 7 1969</i>  |                         | 25B. NAME OF REGISTRAR<br><i>Robert E. Fisher, M.D.</i>   |  | 25C. FUNERAL DIRECTOR<br><i>Mitchell Wiedefeld</i>  |  | ADDRESS<br><i>Home 6500 York Rd. Balto., Md. 21212</i>   |  |   |  |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68

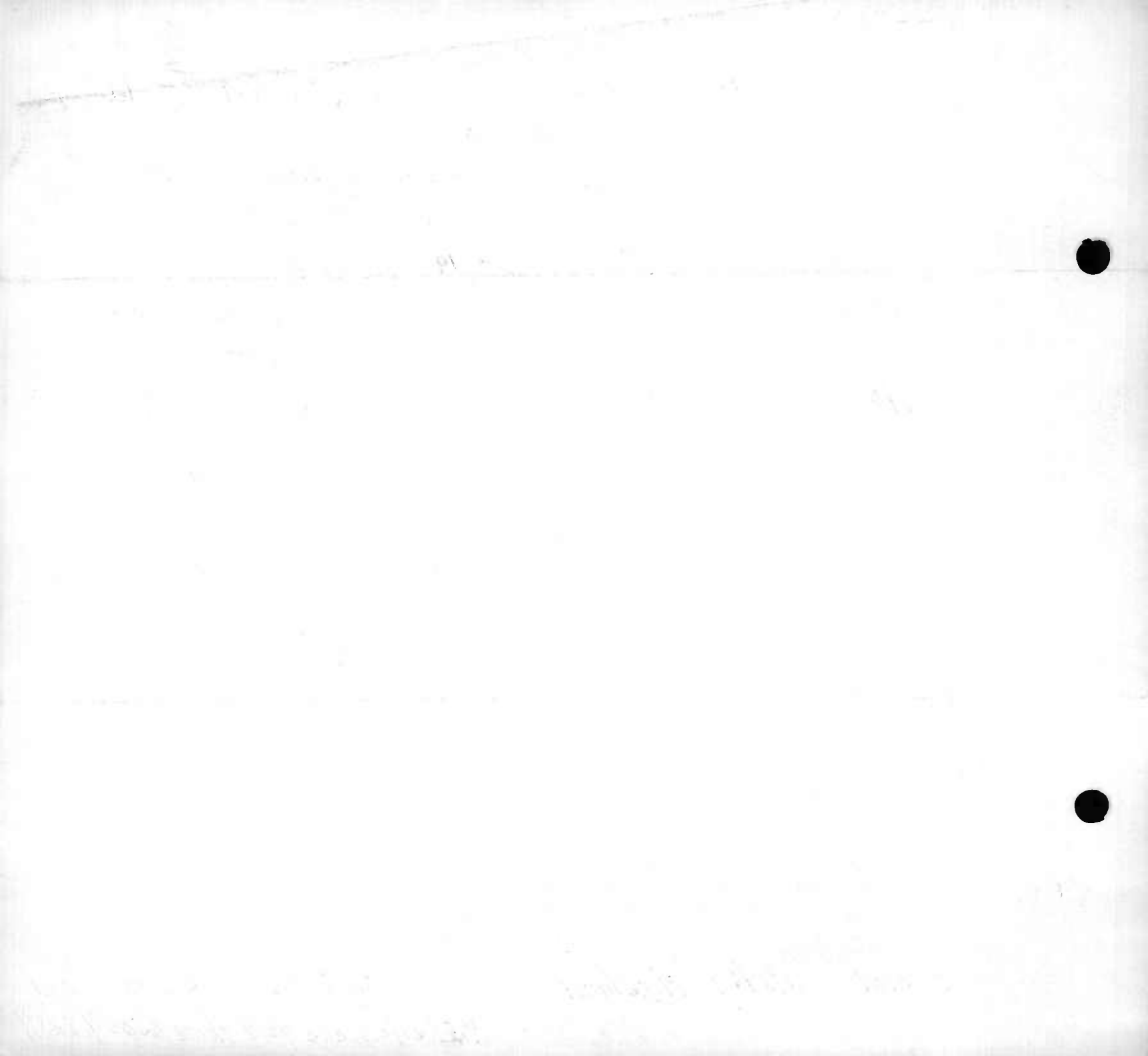
Charles



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| G-360  |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | X REG. NO. 69 10996  |  |
|--|--|--|--|--|--|
| BIRTH NO.  |  | 1. NAME OF DECEASED<br>(Type or Print) <u>THOMAS G. GAITHER</u>  |  | 2. DATE AND HOUR OF DEATH<br><u>Nov. 5, 1969</u> <u>12<sup>55</sup> P.M.</u>   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  | 4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)<br>A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u> |  | 5. CITY OR TOWN <u>BALTIMORE</u> 21207   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>MARYLAND GEN. HOSPITAL</u>  |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |  | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 5. SEX <u>M</u>  |  | 6. RACE <u>W</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH <u>2-19-1904</u>  |  | 9. AGE (In years last birthday) <u>65</u>  |  | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>   |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>  |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  | 13. FATHER'S NAME <u>THOMAS GAITHER</u>  |  | 14. MOTHER'S MAIDEN NAME <u>LOTTIE STREET</u>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>   |  | 16. SOCIAL SECURITY NO. <u>703-03-8971</u>   |  | 17. INFORMANT <u>MRS JANE JACOBS</u> ADDRESS <u>DAUGHTER - SAME</u>  |  |
| 18. <u>519.2 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |  | (A) IMMEDIATE CAUSE <u>Acute Respiratory Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF: <u>2 days</u>                                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| ANTECEDENT CAUSES  |  | (B) <u>Broncho pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: <u>2 DAYS</u>   |  |  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  | (C) <u>Chronic obstructive Pulmonary Disease</u> DUE TO, OR AS A CONSEQUENCE OF: <u>YEARS</u>  |  |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  | <u>Congestive heart failure 20 Cor Pulmonale</u>   |  |  |  |
| 19A. DATE OF OPERATION <u>0</u>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                       |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10-26</u> 19 <u>69</u> to <u>11-5</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>11-5</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |  |  |
| 23A. SIGNATURE <u>Angela A. Topacio</u>  |  | 23B. DATE SIGNED <u>11-5-69</u>  |  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>                          |  |
| 23C. PHYSICIAN'S NAME (Type) <u>ANGELITA A. TOPACIO, MD</u>  |  | 23D. ADDRESS <u>MARYLAND GEN. HOSP.</u>  |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 24B. DATE <u>11/8/69</u>   |  | 24C. NAME OF CEMETERY OR CREMATORY <u>Moreland</u>   |  |
| 24D. LOCATION (City, town, or county) <u>Taybe Ave Balto Md</u>  |  | 25A. DATE REC'D BY HEALTH DEPT. <u>NOV 7 1969</u>  |  | 25B. NAME OF REGISTRAR <u>Robert E. Jones, MD</u>  |  |
| 25C. FUNERAL DIRECTOR <u>Wanda Fold Home</u>   |  | 25D. ADDRESS <u>6500 York Rd</u>   |  |  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                         |   |                                    | REG. NO. <b>69 10997</b>  |
|---|-------------------------|---|------------------------------------|---|
| 8-420   |                         | 69 10997  |                                    | CERTIFICATE OF DEATH  |
| BIRTH NO.   |                         | 1. NAME OF DECEASED<br>(Type or Print) <b>BLOCK, Louis</b>  |                                    |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                         | 2. DATE AND HOUR OF DEATH<br><b>10-31-69 10:30 P.M.</b>   |                                    |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>42 SINAI HOSPITAL</b>  |                         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>2831</b>                          |                                    |   |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |                         | C. CITY OR TOWN<br><b>BALTO.</b>  |                                    | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|   |                         | E. STREET AND NUMBER<br><b>6600 Eberle Dr #15 APT. 203</b>  |                                    |   |
| 5. SEX<br><b>MALE</b>   | 6. RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12/5/93</b> | 9. AGE (In years last birthday)<br><b>75</b>  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETAIL</b>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>GROCE</b>   |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>BALTO. MARYLAND</b>                           |
| 13. FATHER'S NAME<br><b>UNKNOWN</b>   |                         | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                    |   |
| 14. MOTHER'S MAIDEN NAME<br><b>ANNA ?</b>   |                         |   |                                    |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>YES ARMY WWI</b>   |                         | 16. SOCIAL SECURITY NO.<br><b>218-32-0976A</b>  |                                    | 17. INFORMANT<br><b>MRS. ELLA BLOCK, 6600 EBERLE DR., APT. 203</b>                            |
| 18. <b>412.4 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><b>pulmonary emboli</b>   |                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b>  |                                    |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                         | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>ASCVD</b><br><b>3 years</b>   |                                    |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>pneumonia - UTI</b>  |                         |   |                                    |   |
| 19A. DATE OF OPERATION<br><b>10/12/69</b>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                    | 20A. AUTOPSY? (Yes or No)   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)  |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                                    | 21F. HOW DID INJURY OCCUR?  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10/12/69</b> 19 to <b>10/31/69</b> 19 that (I) (we) last saw the deceased alive on <b>10/31/69</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |   |                                    |   |
| 23A. SIGNATURE<br><b>R</b>  |                         | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>                             |                                    | 23B. DATE SIGNED<br><b>10/31/69</b>   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>RAFAEL LEVITER, M.D.</b>   |                         | 23D. ADDRESS<br><b>SINAI HOSPITAL</b>   |                                    |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                         | 24B. DATE<br><b>11-2-69</b>   |                                    | 24C. NAME of CEMETERY or CREMATORY<br><b>CHIZUK AMUNO (ARLINGTON)</b>                         |
| 24D. LOCATION<br><b>W. ROGERS AVENUE, MARYLAND</b>  |                         |   |                                    |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 7 1969</b>  |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor</b>   |                                    | 25C. FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BROS. 6010 REISTERSTOWN RD.</b>                |

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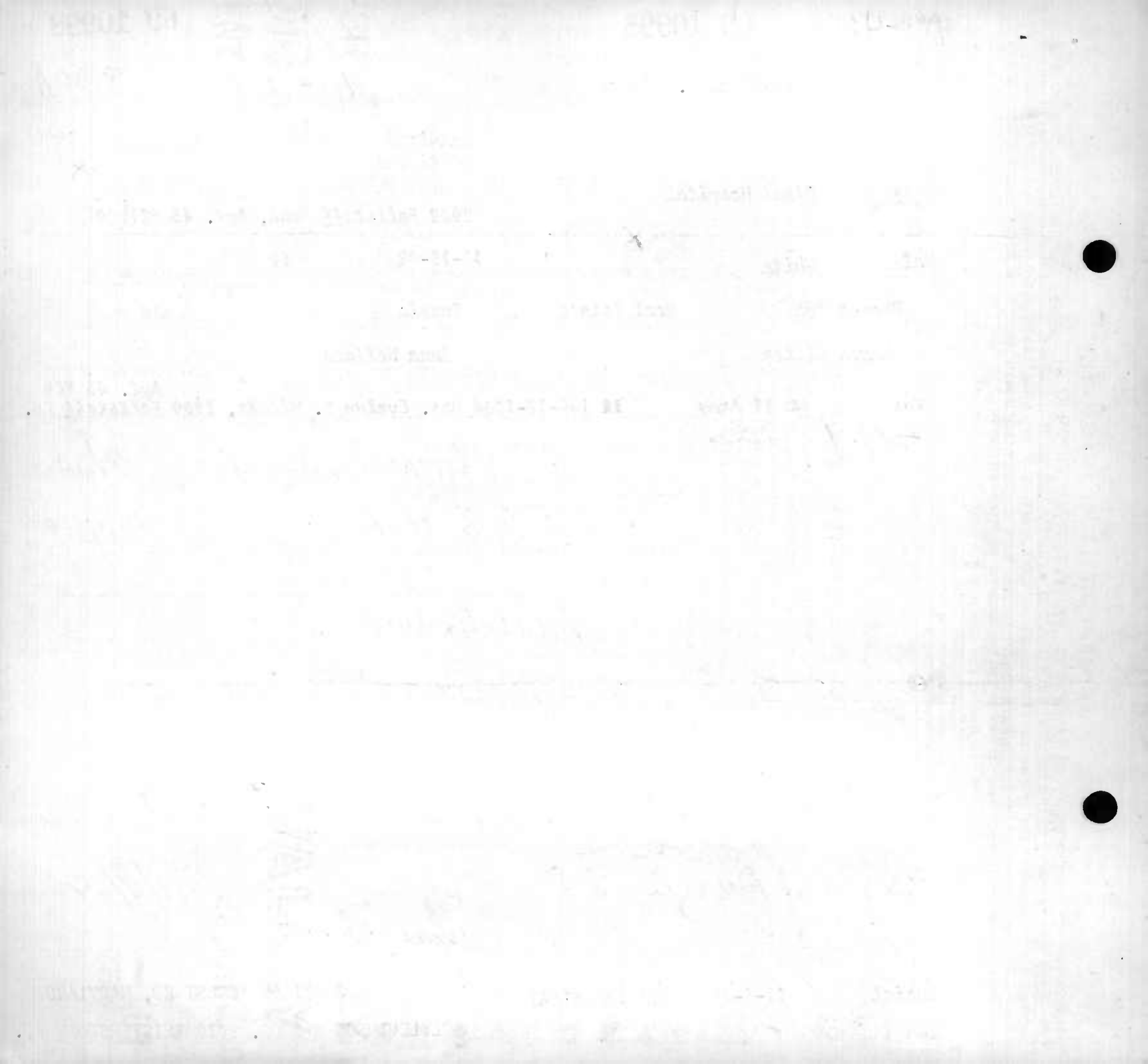
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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| M-460  |  | 69 10998   |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. 69 10998  |  |
| BIRTH NO.  |  |  |  | 1. NAME OF DECEASED<br>(Type or Print)  |  |  |  |
|  |  |  |  | Montfort G. Miller  |  |  |  |
| 2. DATE AND HOUR OF DEATH  |  |  |  | 11/4/69 8:30 A.M.   |  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)             |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION   |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) |  | A. STATE  |  | B. COUNTY  |  |
| 42 Sinai Hospital  |  |  |  | Maryland  |  | Baltimore  |  |
| 5. SEX   |  |  |  | 6. DATE OF BIRTH  |  |  |  |
| Male   |  | White  |  | 10-18-09  |  | 60   |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>  |  |  |  | 9. AGE (In years last birthday)   |  |  |  |
| WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |   |  |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |  |  | 11. BIRTHPLACE (State or foreign country)   |  |  |  |
| Proprietor   |  |  |  | Russia  |  |  |  |
| 13. FATHER'S NAME  |  |  |  | 14. MOTHER'S MAIDEN NAME  |  |  |  |
| Mayer Miller   |  |  |  | Anna Helfand  |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |  |  |  | 16. SOCIAL SECURITY NO.   |  |  |  |
| Yes WW II Army   |  |  |  | 145-12-1064   |  |  |  |
| 17. INFORMANT  |  |  |  | ADDRESS   |  |  |  |
| Mrs. Evelyn S. Miller  |  |  |  | Apt. 43 #09 Fallstaff Rd.   |  |  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH   |  |  |  | CAUSE OF DEATH  |  |  |  |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)   |  |  |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:   |  |  |  |
| ANTECEDENT CAUSES  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF:   |  |  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF:   |  |  |  |
| II   |  |  |  | Diabetes mellitus   |  |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| 19A. DATE OF OPERATION   |  |  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)  |  |
|  |  |  |  |   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?     |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)  |  |  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)          |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |  |  |  | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not White At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from 19 50 to present 19 11/4 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 23A. SIGNATURE   |  |  |  | 23B. DATE SIGNED  |  |  |  |
| Bernard Burgin M.D.  |  |  |  | 11/4/69   |  |  |  |
| 23C. PHYSICIAN'S NAME (Type)   |  |  |  | 23D. ADDRESS  |  |  |  |
| Bernard Burgin, M.D.   |  |  |  | Sinai Hospital  |  |  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)  |  | 24B. DATE  |  | 24C. NAME OF CEMETERY or CREMATORY  |  | 24D. LOCATION (City, town, or county) (State)                            |  |
| Burial   |  | 11-5-69  |  | NEW HAV SINAI   |  | GARRISON FOREST RD, MARYLAND   |  |
| 25A. DATE REC'D BY HEALTH DEPT.  |  |  |  | 25B. NAME OF REGISTRAR  |  | 25C. FUNERAL DIRECTOR  |  |
| NOV 7 1969   |  |  |  | Robert E. Taylor, M.D.  |  | SOL LEVINSON & BROS. 6010 REISTERSTOWN RD.                               |  |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-410 69 10999 CERTIFICATE OF DEATH BALTIMORE CITY HEALTH DEPARTMENT REG. NO. 69 10999

BIRTH NO. 1. NAME OF DECEASED (Type or Print) *Reba Woolf* 2. DATE AND HOUR OF DEATH *November 4/69 4:28 A.M.*

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) *00 5902 Winner Ave* 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE *Maryland* B. COUNTY *2740* C. CITY OR TOWN *Baltimore* D. INSIDE CITY LIMITS? YES ☒ NO ☐ E. STREET AND NUMBER *5902 Winner Ave #21215*

5. SEX *Female* 6. RACE *White* 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 8. DATE OF BIRTH *July 14/1891* 9. AGE (In years lost birthday) *78* If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *Housewife* 10B. KIND OF BUSINESS OR INDUSTRY *at Home* 11. BIRTHPLACE (State or foreign country) *Baltimore, Md* 12. CITIZEN OF WHAT COUNTRY? *USA*

13. FATHER'S NAME *Samuel Jacobson* 14. MOTHER'S MAIDEN NAME *Ida ?*

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) *No.* 16. SOCIAL SECURITY NO. 17. INFORMANT *Mrs Ruth Lebron - 5902 Winner Ave* ADDRESS *Ave*

18. *201 X I* CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: *Hodgkins Disease* (B) DUE TO, OR AS A CONSEQUENCE OF: (C) ANTICIPATED CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. *Stroke due to arteriosclerotic*

19. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐ 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED White At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

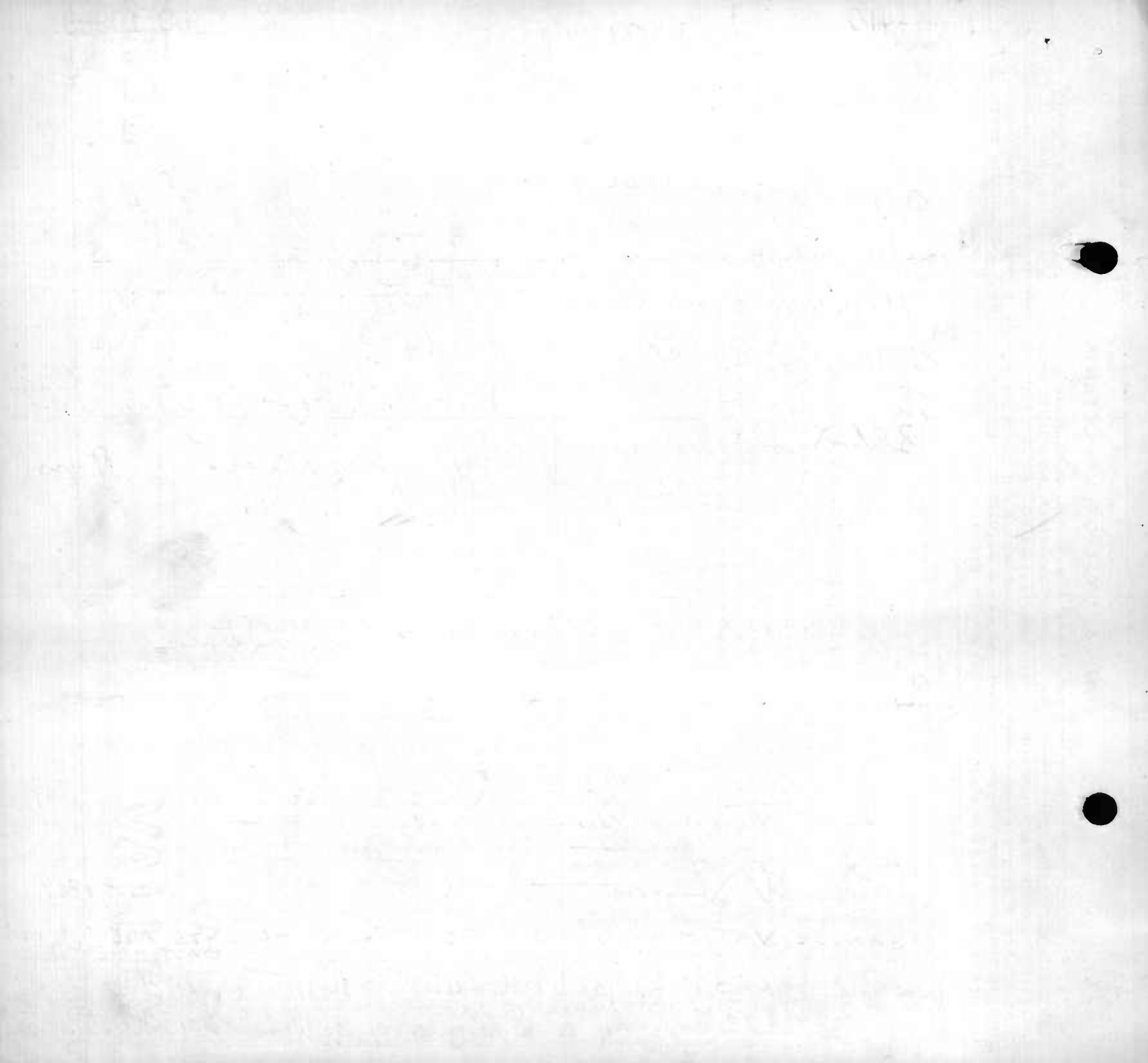
22. I certify that (I) (the hospital) attended the deceased from *Jan 2 1962* to *Nov 4 1969*, that (I) (we) last saw the deceased alive on *Nov 3 1969* and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE *Samuel V. Tomparou* 23B. DATE SIGNED *Nov 4, 1969* Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23C. PHYSICIAN'S NAME (Type) *SAMUEL V. TOMPAROU, MD* 23D. ADDRESS *7211 PARK HEIGHTS AVE 21208 BALTIMORE, MD*

24A. BURIAL CREMATION, REMOVAL (Specify) *Burial* 24B. DATE *NOV 5/69* 24C. NAME OF CEMETERY OR CREMATORY *Rega Kaulander* 24D. LOCATION *Redgate, Md Rd*

25A. DATE REC'D BY HEALTH DEPT. *NOV 7 1969* 25B. NAME OF REGISTRAR *Reba E. Fisher, MD* 25C. FUNERAL DIRECTOR *Sal Leonardi* ADDRESS *6010 Kestelton Ave*





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 11000

BIRTH NO.

|   |  |   |  |
|---|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br>Nowell Johnson  |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> M. |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>46 Lutheran Hospital  |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br>11 3 69 6:40 A.M.   |  |
| 6. SEX<br>Male  |  | 7. RACE<br>Negro  |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | C. CITY OR TOWN<br>Baltimore  |  |
| 9. DATE OF BIRTH<br>Mar 15, 1919  |  | 10. AGE (In years lost birthday)<br>50  |  |
| 11. BIRTHPLACE (State or foreign country)<br>Columbus, S. Carolina  |  | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME<br>Obed Johnson   |  | 14. MOTHER'S MAIDEN NAME<br>Susie Nowell  |  |
| 15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Postal clerk  |  | 16. KIND OF BUSINESS OR INDUSTRY<br>U.S. Post Office  |  |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>Yes 20 Jan 43 9 Feb 46   |  | 18. SOCIAL SECURITY NO.<br>244 18-6044  |  |
| 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>Acute delirium tremens<br>DUE TO, OR AS A CONSEQUENCE OF: complicating fracture of pelvis<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br>II   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 20A. DATE OF OPERATION<br>2   |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 21. AUTOPSY? (Yes or No)<br>yes   |  |   |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>Street              |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br>2900 blk. Garrison Blvd.  |  | 22D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY (APPROX.)<br>10 30 69 10 P m.                          |  |
| 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  | 22F. HOW DID INJURY OCCUR?<br>Pedestrian struck by auto   |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <i>R. S. Fisher</i> M.D.<br>EXAMINER'S NAME (Type) Russell S. Fisher, M.D.<br>CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED 11-3-69 |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |  | 24B. DATE<br>Nov. 6, 1969   |  |
| 24C. NAME OF CEMETERY or CREMATORY<br>Baltimore Nat. Cem.   |  | 24D. LOCATION (City, town, or county) (State)<br>554 Indian Cr. Balto., Md.                                     |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 7 1969   |  | 25B. NAME OF REGISTRAR<br>Robert E. Fisher, M.D.  |  |
| 25C. FUNERAL DIRECTOR<br>Joseph L. Ross   |  | 25D. ADDRESS<br>2222 W. North Ave.  |  |

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